

65 13001

BALTIMORE CITY HEALTH DEPARTMENT

65 13001

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH T. GEPHARDT

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1965 6:30 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Roadside - 801 Key Highway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

New York

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Massquequa Park

D. STREET ADDRESS (If rural, give location)

235 McKinley Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

4/16/23

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Photo Engraver

10B. KIND OF BUSINESS OR INDUSTRY

Engraving

11. BIRTHPLACE (State or foreign country)

New York, N.Y.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Joseph Gebhardt

14. MOTHER'S MAIDEN NAME

Catherine Cavanagh

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

Yes

WW 11

16. SOCIAL
SECURITY NO.

228-11-3180

17. INFORMANT

ADDRESS

Dalton Funeral Home Floral Park, N.Y.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hanging.
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Roadside

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

801 Key Highway

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 17 '65 A

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hanged self from pole.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/17/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

12/21/65

23C. NAME of CEMETERY or CREMATORY

Arlington National

23D. LOCATION

(City, town, or county)

(State)

Arlington, Va.

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

24B. NAME OF REGISTRAR

Robert E. Feltner, M.D.

24C. FUNERAL DIRECTOR 1217 St. Paul St ADDRESS

Wm. Cook-Brooks Inc Baltimore, Md. 21202

VALLEY FORD

IMMEDIATE

100-100000-1

100-100000-1

100-100000-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13002 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13002 | |
|---|-------------------------|---|---|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Susie Rogers | | | | 2. DATE AND HOUR OF DEATH December 13, 1965 10:30 a. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division St. Baltimore, Maryland 21217 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, D. STREET ADDRESS (If rural, give location) 1128 N. Carrollton Ave. | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 4, 1893 | | 9. AGE (In years last birthday) 72 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign) Maryland, Calvert Co | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? | | | | 14. MOTHER'S MAIDEN NAME Barbara Jane | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Charles E. Rogers 1128 Carrollton Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 170X1 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Congestive heart failure with 2 months DUE TO car pulmonale (B) Pulmonary fibrosis and metastatic 1 year DUE TO carcinoma of lymphatic system (C) Radiation therapy for carcinoma 4 years of breast | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-10-65 19 to 12-13-65 19, that (I) (we) lost saw the deceased alive on 12-13-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Roland T. Smoot | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-14-65 | |
| 23C. PHYSICIAN'S NAME (Type) Roland T. Smoot | | | | 23D. ADDRESS M.D. 3817 Glyn Rd, Balt. 15, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/16/65 | | 24C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR Roland T. Smoot | | 25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------------|--|--|---|---|
| BIRTH NO. 65 13003 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13003 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) GABRIEL WASHINGTON | | 2. DATE AND HOUR OF DEATH DEC. 16, 1965 3:00 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2309 Roslyn Avenue | | A. STATE Maryland B. COUNTY 15-04 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2005 Bryant Ave. | | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED Widowed | 8. DATE OF BIRTH Jan. 25, 1880 | 9. AGE (In years last birthday) 95 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef Cook | | 10B. KIND OF BUSINESS OR INDUSTRY Elkridge Club | | 11. BIRTHPLACE (State or foreign country) Essex Co. Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Abselon Washington | | 14. MOTHER'S MAIDEN NAME Eliza | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 216-10-7698 | | 16. SOCIAL SECURITY NO. 216-10-7698 | | 17. INFORMANT ADDRESS Mary E. Fitchett-2005 Bryant Ave. | |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease | | CAUSE OF DEATH (A) Arteriosclerotic heart disease DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 5 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 3, 1965 to Dec. 16, 1965 , that (I) (we) last saw the deceased alive on Dec. 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Abraham B. Hurwitz | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec. 16, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ | | 23D. ADDRESS 7501 Liberty Road, Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/20/65 | | 24C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR O. E. S. E. S. | | 25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave | |

FUNERAL DIRECTOR: IMPORTANT

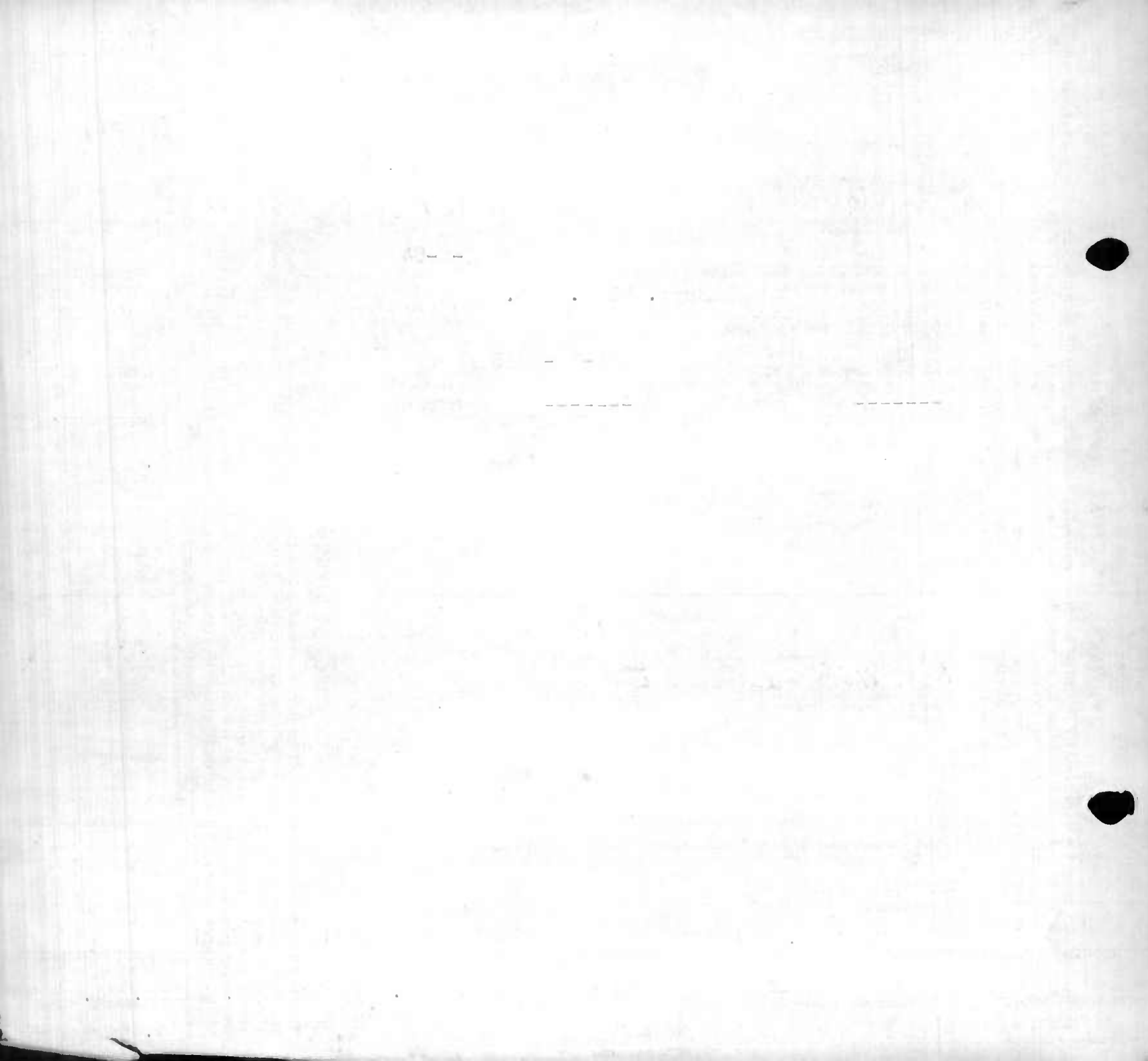
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|---|---|--|--|
| BIRTH NO. 65 13004 | | CERTIFICATE OF DEATH | | Registered No. 65 13004 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WINNER B. HARTLOVE | | 2. DATE AND HOUR OF DEATH 12/20/65 1:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7 Mercy Hosp. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Loch Raven Village | |
| | | D. STREET ADDRESS (If rural, give location) 8313 Dalesford Road | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED (Specify) | 8. DATE OF BIRTH 10-26-1916 | 9. AGE (In years lost birthday) 49 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coordinator | | 10B. KIND OF BUSINESS OR INDUSTRY Ship yards | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Charles W. Hartlove | | | 14. MOTHER'S MAIDEN NAME Katherine Bauersfeld | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-07-1126 | | 17. INFORMANT ADDRESS Jean Hartlove 8313 Dalesford Rd. | |
| 18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE BRONCHOPNEUMONIA (A) DUE TO | | CAUSE OF DEATH GENERALIZED CARCINOMATOSIS (B) DUE TO UNDIFFERENTIATED BRONCHOCARCINOMA (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 DAYS @ LEAST 2 HOURS " | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-9 19 65 to 12/20 19 65 , that (I) (we) lost saw the deceased alive on 12/20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David J. Gillis M.D. | | | | 23B. DATE SIGNED 12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID J. GILLIS M.D. | | | | 23D. ADDRESS MERCY HOSP. - BALTO., MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-23-65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Charles H. Taylor & Son 8802 Nantux Rd | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

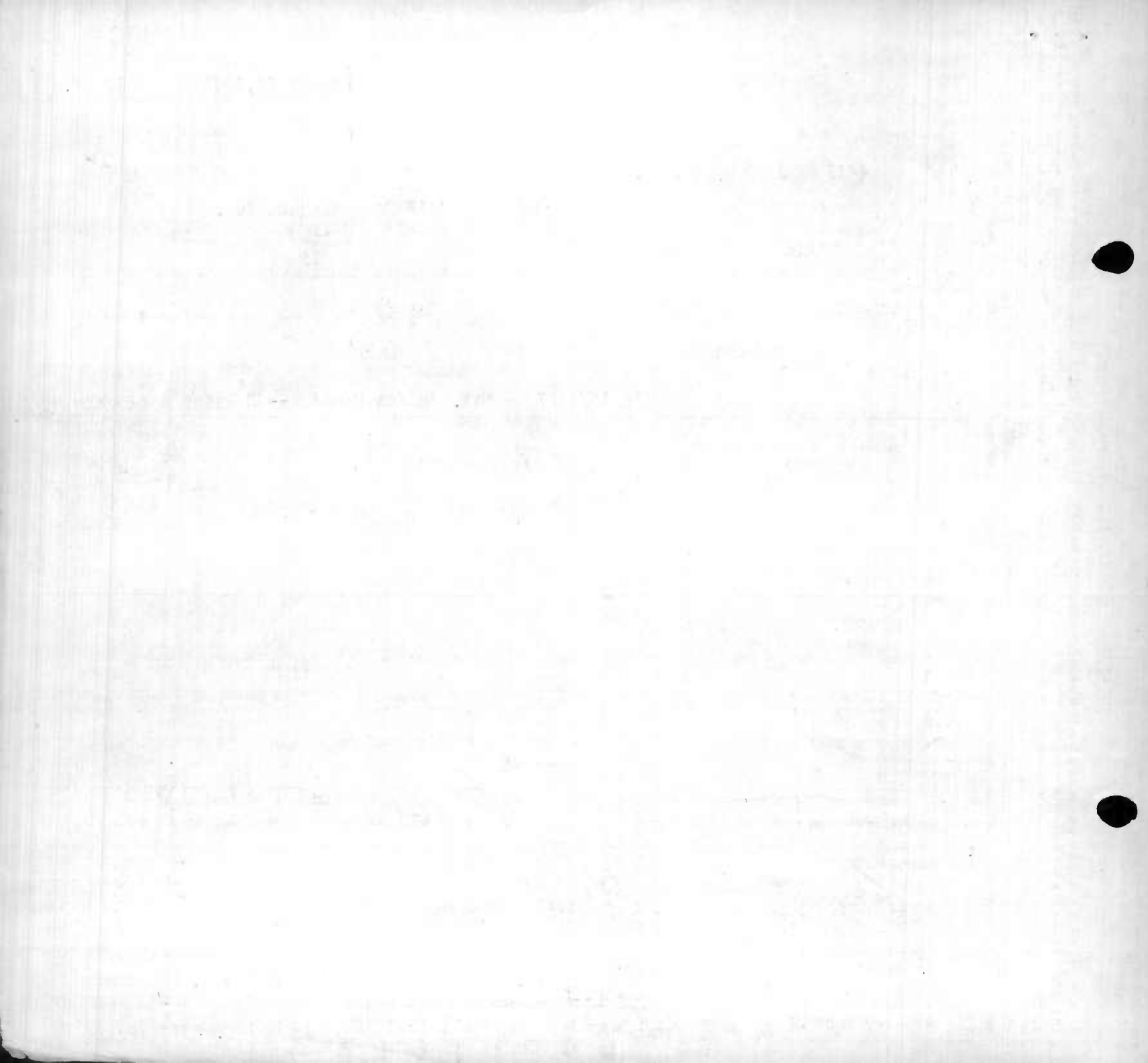
| BIRTH NO. 65 13005 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13005 | |
|--|---------------------|---|-----------------------------------|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>William Charles Menger</i> | | | | 2. DATE AND HOUR OF DEATH <i>12-20-65</i> <i>15:00 A M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2303</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1618 Clarkson Street</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>5-8-84</i> | 9. AGE (In years last birthday) <i>81</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Supt. Bldg. Ret. unknown</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>William Menger</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Ann Potash</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown none</i> | | 16. SOCIAL SECURITY NO. <i>081-10-3358 unknown</i> | | 17. INFORMANT <i>Hospital Chart</i> | | | |
| 18. <i>143X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> | | | | CAUSE OF DEATH (A) <i>SQUAMOUS Cell carcinoma of floor of mouth</i> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>9 mos.</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Left Lower Lobe Pneumonia and Atelectasis</i> | | | | <i>5 days</i> | | | |
| 19A. DATE OF OPERATION <i>12-17-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Left Lower Lobe Pneum + Atel.</i> | | 20A. AUTOPSY? (Yes or No) <i>N</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>NO</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NO</i> | | 21C. WHERE DID INJURY OCCUR? <i>NO</i> | | If in Baltimore City, give exact location | |
| 21D. TIME OF INJURY (APPROX.) <i>NO</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> <i>NO</i> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>NO</i> | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <i>11-30</i> <i>1965</i> to <i>12-20</i> <i>1965</i> , that (H) (we) last saw the deceased alive on <i>12-20</i> <i>1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Henry A. Saiontz</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-20-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Henry A. Saiontz</i> | | | | 23D. ADDRESS <i>University Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/23/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Taylor Ave. Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1965</i> | | 25B. NAME OF REGISTRAR <i>R. E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>KRAUSE FUNERAL HOME</i> | | ADDRESS <i>1216 S. Charles S</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13006 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13006 | |
|--|--|--|--|--|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | HYMAN VINNICK | | December 18, 1965 10 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | Maryland | | B. COUNTY | |
| 4613 Park Heights Ave. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | | | 4613 Park Heights Ave. | | 27-16 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Male | | White | | Separated | | 95 | |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Merchant | | Retail | | Russia | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Unknown | | | | Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| 216/16/6627 | | | | Mrs. Julius Vinnick-- & | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Pneumonia | | Several days | |
| ANTECEDENT CAUSES | | | | Generalized atherosclerosis | | Several years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | (C) DUE TO | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19. DATE OF OPERATION | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 22. I certify that (I) (this hospital) attended the deceased from 1965 to Dec 18 1965 | | that (I) (we) last saw the deceased alive on Dec 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Seymour H. Rubin | | | | 12/19/65 | | 5415 Park Heights Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | | | 12/19/65 | | Hebrew Young Men | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF FUNERAL DIRECTOR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 22 1965 | | | | SOL LEVINSON & BROS INC. | | 6010 Reist Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 13007 | |
|---|-----------|--|------------------|--|--|
| BIRTH NO. 65 13007 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GOLDBERG, SARAH | | 2. DATE AND HOUR OF DEATH December 19, 1965 11:55 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP. | | A. STATE Maryland B. COUNTY B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 8909 Maplebrook Road | | | |
| | | D. STREET ADDRESS (If rural, give location) 53-00 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 75 yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State, foreign country) Maryland | |
| 13. FATHER'S NAME Henry Goldberger | | 14. MOTHER'S MAIDEN NAME Hannah | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Daughter ADDRESS 8909 Maplebrook Rd. | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO Diabetic Arteriosclerosis with Intestinal Obstruction | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO with | | | |
| | | (C) Auricular Fibrillation | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-19-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obst. | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-14 19 65 to 12-19 19 65, that (I) (we) lost saw the deceased alive on 12-19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE RITA SUAREZ | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) NENITA SUAREZ | | 23D. ADDRESS FRANKLIN SQUARE HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/22/65 | | 24C. NAME OF CEMETERY or CREMATORY MOSES MONTIFILORE HEBREW WOODMORE | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|---|--|---|---|
| BIRTH NO. 65 13008 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13008 | |
| 1. NAME OF DECEASED (Type or Print) HARRISON Flora | | | 2. DATE AND HOUR OF DEATH Dec. 16, 1965 2:15 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Baltimore Maryland B. COUNTY Baltimore, Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. D. STREET ADDRESS (If rural, give location) 3302 Clarks Lane 21215 | | |
| 5. SEX ♀ | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11/22/1909 | 9. AGE (in years last birthday) 56 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Israel David Steinbach | | | 14. MOTHER'S MAIDEN NAME Rose Roum | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Sister (Dorothy Weiner Miami Beach, Fla.) | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 170X I Pulmonary Carcinoma (metastases) | | CAUSE OF DEATH (A) DUE TO Pulmonary Carcinoma (metastases) | | INTERVAL BETWEEN ONSET AND DEATH 8 mos. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of left breast 3 years | | (B) DUE TO | | | |
| (C) Carcinoma of left breast 3 years | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bone Metastases; Adrenal Metastases 8 mos. | | | | | |
| 19A. DATE OF OPERATION May 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bilateral adrenalectomy for adrenal metastases | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (home, farm, factory, street, public place, etc.) None | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None | |
| 21D. TIME OF INJURY (APPROX.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? None | |
| 22. I certify that (I) this hospital attended the deceased from 11/29/65 to 12/16/65 , that (I) we lost saw the deceased alive on 12/16/65 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George Banks M.D. GEORGE BANKS | | | | 23B. DATE SIGNED 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) GEORGE BANKS | | | | 23D. ADDRESS Sinai Hospital | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/17/65 | | 24C. NAME OF CEMETERY or CREMATORY Beth Namedush Synagogue | |
| 24D. LOCATION (City, town, or county) (State) Riverside, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | | |
| 25B. NAME OF REGISTRAR R. E. F. Jones | | 25C. FUNERAL DIRECTOR Vol. Levy & Sons Inc. 6010 Ruston Rd. | | | |

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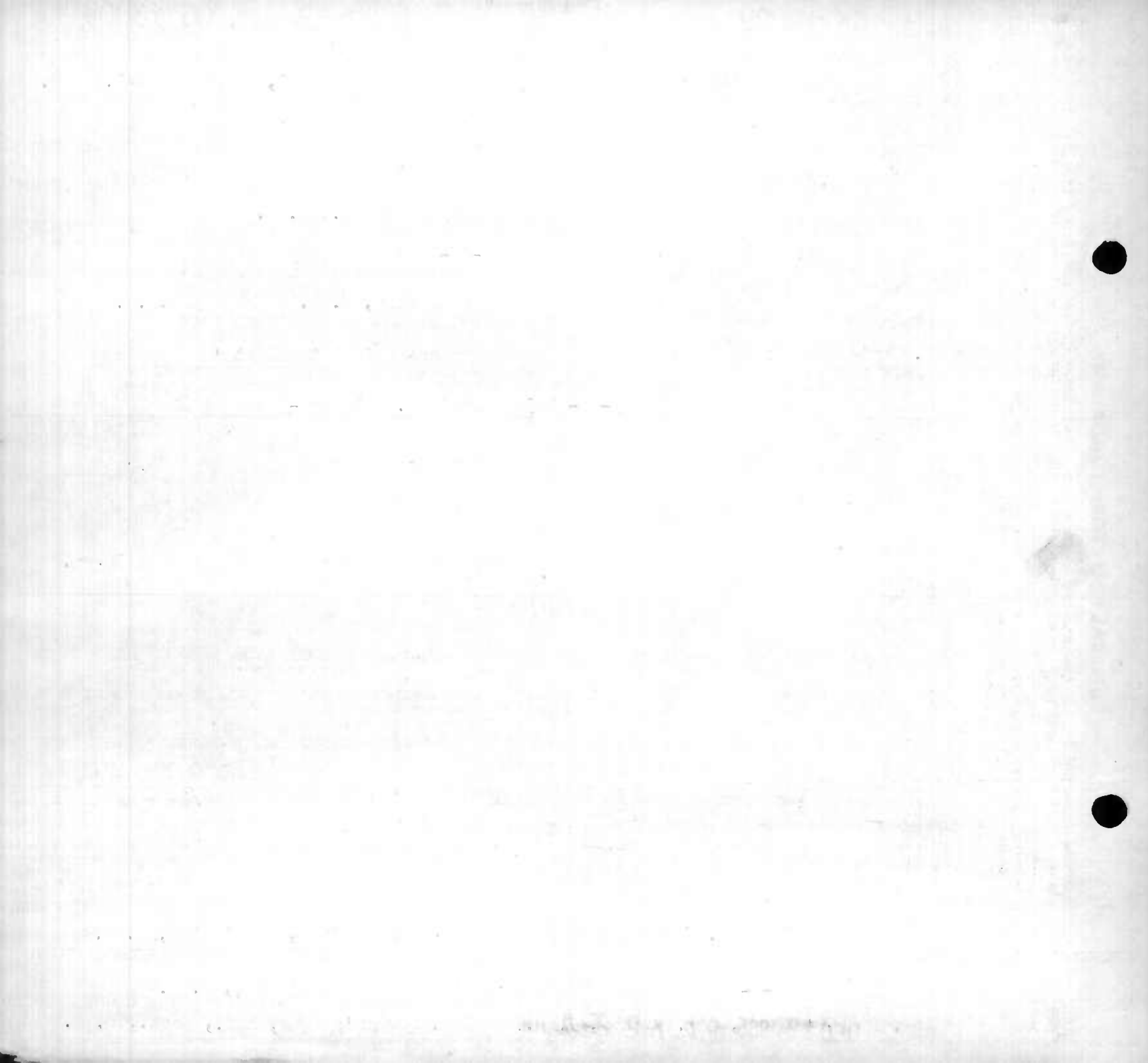
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

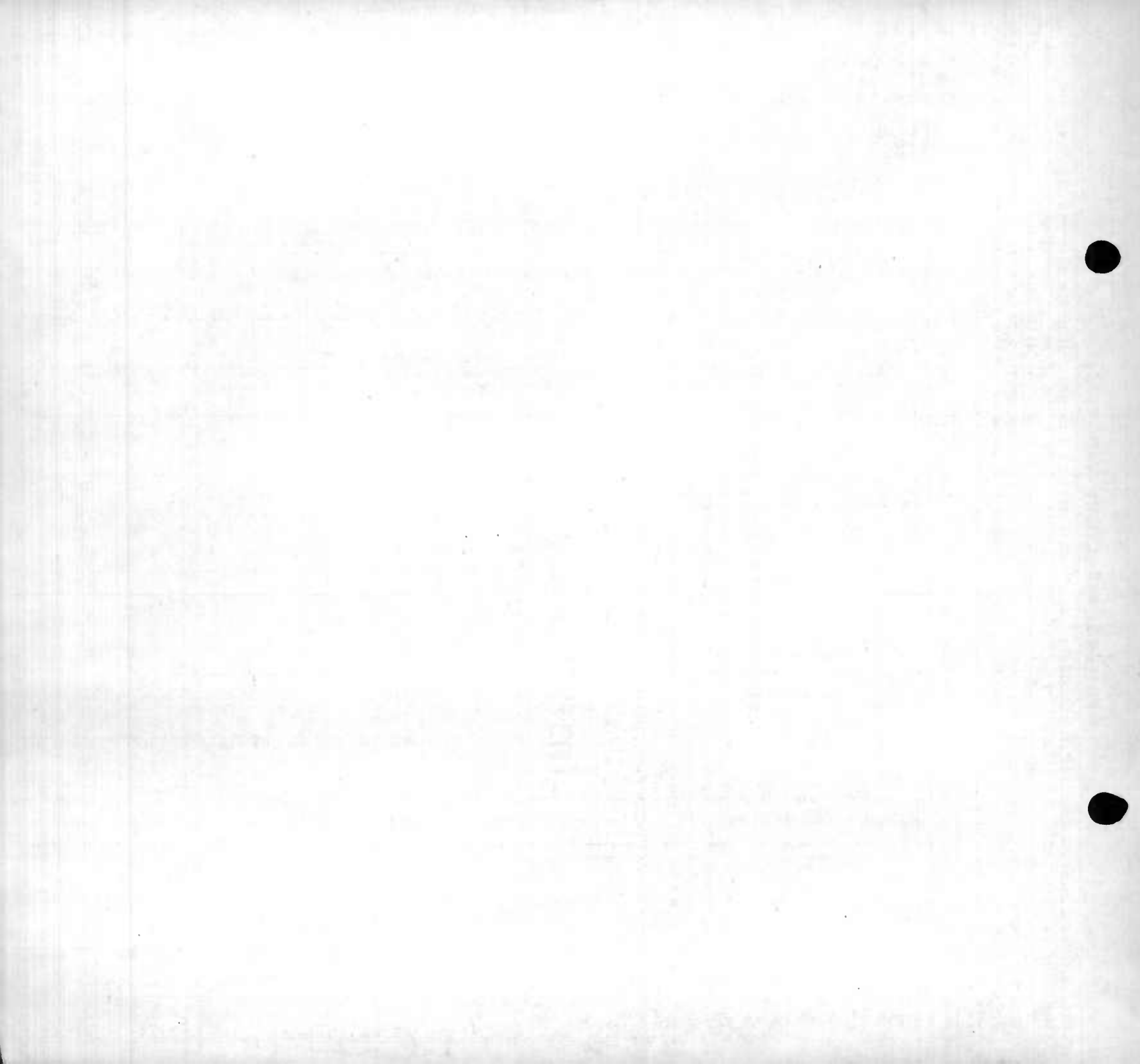
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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13009 | |
| BIRTH NO. 65 13009 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Paul John Seltzer | | 2. DATE AND HOUR OF DEATH December 3, 1965 3.05 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital DOA | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE District of Columbia B. COUNTY Washington C. CITY OR TOWN (If outside city limits, write RURAL and give township) Washington D. STREET ADDRESS (If rural, give location) 3215 45th St., N. W. | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-30-1900 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive | | 10B. KIND OF BUSINESS OR INDUSTRY Banking | 9. AGE (In years last birthday) 65 years |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME U. David Seltzer | | 14. MOTHER'S MAIDEN NAME Barbara Elizabeth Light | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 579-01-5283 | 17. INFORMANT Marie V. Seltzer - Same as #2 |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cardiac Arrhythmia DUE TO Coronary Occlusion (B) DUE TO (C) Atherosclerotic Heart Disease | |
| INTERVAL BETWEEN ONSET AND DEATH Moments | | Moments | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 2 1/3 yrs. | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the physician) attended the deceased from 3/16 19 59 to 12/3 19 65 , that (I) (we) last saw the deceased alive on 11/16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | |
| 23A. SIGNATURE Michel M. Healy | | 23B. DATE SIGNED 12/3/65 | |
| 23C. PHYSICIAN'S NAME (Type) Michel M. Healy | | 23D. ADDRESS Washington Clinic, Washington, D. C. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-7-65 | 24C. NAME of CEMETERY or CREMATORY Congressional Cemetery | 24D. LOCATION (City, town, or county) (State) Washington, D. C. |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | 25B. NAME OF REGISTRAR Robert E. Taylor | 25C. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc., Wash., D. C. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13010 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13010 | |
|--|-------------------------|---|------------------------------------|---|---|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Andrew P. Budzynski</u> | | | | 2. DATE AND HOUR OF DEATH <u>12/18/65</u> <u>1</u> <u>A</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>B1 Baltimore City Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>806 S. Potomac Street</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>2-17-09</u> | 9. AGE (In years last birthday) <u>56</u> | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern owner</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Liquor sales</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Peter</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Johanna Kiecal</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>417-055624</u> | | 17. INFORMANT <u>Mrs. Andrew P. Budzynski</u> | | ADDRESS <u>806 S. Potomac St., Baltimore Md</u> | |
| 18. <u>433.11260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anteriosclerotic C.V.</u> DUE TO <u>DISEASE E CARDIAC DECOMPENSATION & ATRIAL Fibrillation</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>1) DIABETES MELLITUS.</u> | | | | <u>1 year.</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 3, 1955</u> to <u>DEC 18, 1965</u> , that (I) (we) last saw the deceased alive on <u>DEC 1, 1965</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Henry J. Houska</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/20/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HENRY J. HOUSKA</u> | | | | 23D. ADDRESS <u>333 S. EAST AVE BALTO-21224</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12-21-65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1965</u> | | 25B. NAME OF REGISTRAR <u>R. E. J. J. J.</u> | | 25C. FUNERAL DIRECTOR <u>Nicholas Mathews</u> | | | |
| | | | | ADDRESS <u>3021 EASTERN AVE.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

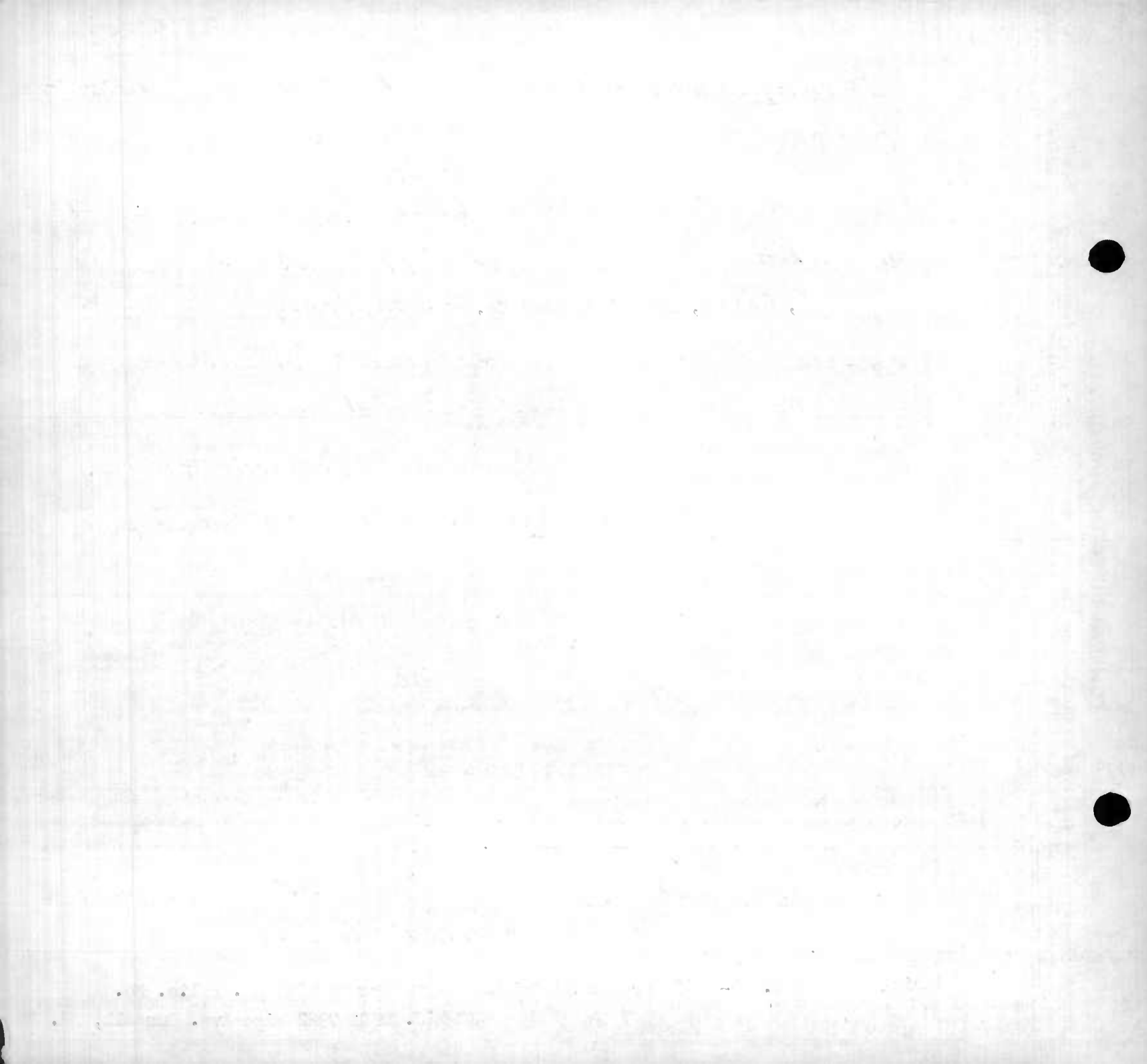
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13011 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13011 | |
|---|-------------------------|---|---|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Sister Gertrude Kelly (Anna) | | | | 2. DATE AND HOUR OF DEATH Dec. 20, 1965 1:55 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 4000 Forest Hill Road FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Villa St. Michael | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4000 Forest Hill Road | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married | 8. DATE OF BIRTH Dec. 23, 1880 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | | 10B. KIND OF BUSINESS OR INDUSTRY Hospital | | 11. BIRTHPLACE (State or foreign country) Syracuse, New York | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Patrick Kelly (Ireland) | | | | |
| 14. MOTHER'S MAIDEN NAME Mary Flynn (Ireland) | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | |
| 16. SOCIAL SECURITY NO. None | | | 17. INFORMANT Sister Mary Louise, 4000 Forest Hill Rd. | | | | |
| 18. 450.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 yrs. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1961 to Dec. 20, 1965 , that (I) (we) last saw the deceased alive on Dec. 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Damian P. Alagia M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED Dec. 20, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) Damian P. Alagia | | | | 23D. ADDRESS 3326 Audesirk Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/65 | | 24C. NAME of CEMETERY or CREMATORY St. Joseph's | | 24D. LOCATION (City, town, or county) (State) Emmitsburg, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR R. E. Johnson | | 25C. FUNERAL DIRECTOR Stewart & Mowen Company | | 25D. ADDRESS 108 W North Av. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13012 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13012 | |
|--|------------------|---|------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) PENNA, JAMES Silvio | | | | 2. DATE AND HOUR OF DEATH 12-20-65 12:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-06 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 6226 FAIR OAKS AVE. 21214 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10-25-97 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver, Retired, Bethlehem Steel Co. | | | | 10B. KIND OF BUSINESS OR INDUSTRY GENOA, ITALY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME VIENAZIO PENNA | | | | 14. MOTHER'S MAIDEN NAME CATHERINE Di CASAGRANDE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No | | | | 16. SOCIAL SECURITY NO. 213-09-3665 | | 17. INFORMANT ADDRESS Hospital Records. | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL THROMBOSIS - RT. HEMIPARESIS 2 Mo | | | | CAUSE OF DEATH (A) MYOCARDIAL INFARCTION 4 HOURS. DUE TO (B) ARTERIOSCLEROTIC HEART DISEASE 64 years DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from November 24, 1965 to December 20, 1965, that (X) (we) last saw the deceased alive on December 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Thomas P. Connelly | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) THOMAS P. CONNELLY | | | | 23D. ADDRESS Montebello State Hospital. | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 23-1965 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith | | 24D. LOCATION (City/Town, or county) (State) Trumps Mill Rd. Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR R. E. E. E. | | 25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 22 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

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BIRTH NO.

65 13014

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 13014

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BANKS G. THOMPSON

2. DATE AND HOUR PRONOUNCED DEAD

12/17/65 8:32 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2401 W. Lanvale St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

never married

8. DATE OF BIRTH

June 2, 1927

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

HI SCHOOL TEACHER

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ISAAC E. THOMPSON

14. MOTHER'S MAIDEN NAME

INEZ BANKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES, WW1

16. SOCIAL
SECURITY NO.

17. INFORMANT

JOSEPH A. THOMPSON, 3317 ARMSTRONG RD., RICHMOND, VA.

ADDRESS

18.

E 823.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

MULTIPLE INJURIES.

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Jones Falls Expwy. near Cold Spring La.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12 17 65 7:57 p.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver of auto which
ran off road and down embankment

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/18/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

20 DEC 65

23C. NAME OF CEMETERY or CREMATORY

PLEASANT GROVE

23D. LOCATION

AMELIA Co.

(City, town or county)

(State)

VA.

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

R.F.D. 3

ADDRESS

AMELIA, VIRGINIA

VALLEY FORGE

AT 1211 N

1211 N

1211 N
1211 N

F455

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

Booker T. Flemons (Flemmons)

2. DATE AND HOUR PRONOUNCED DEAD

12/17/65 10:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2533 W. North Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M.

8. DATE OF BIRTH

1-11-1932

9. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Roofing

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Tallahassee, OKLA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Flemmons

14. MOTHER'S MAIDEN NAME

MARY E. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

443-304241

17. INFORMANT

E. Flemmons

ADDRESS

4127 Forrest Pk.

18. E 9821

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) STAR WOUND OF CHEST INVOLVING THE

DUE TO

RIGHT LUNG.

(B) DUE TO

(C)

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

house

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

4127 Forrest Pk. Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12/17/65 9:10 p.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

stabbed during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/18/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-26-65

23C. NAME of CEMETERY or CREMATORY

Muskogee

23D. LOCATION

Cem. Muskogee

(City, town, or county)

OKLA.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Morton D. Dyer

ADDRESS

1701 Laurens ST.

WALLER FORGE

WALLER FORGE

WALLER FORGE

WALLER FORGE

WALLER FORGE

WALLER FORGE

WALLER FORGE

WALLER FORGE

WALLER FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|---|--|--|
| BIRTH NO. 65 13016 | | BALTIMORE CITY HEALTH DEPT. | | Registered No. 65 13016 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Elvira Taylor | | | 2. DATE AND HOUR OF DEATH December 20, 1965 10:45a M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3504 Fairview Avenue | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 4-19-1888 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | 13. FATHER'S NAME JAMES BARNES | | |
| 14. MOTHER'S MAIDEN NAME EMMA BARNES | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. 219-16-6330 | | | 17. INFORMANT ADDRESS Mrs. Anita Pleasant 3504 Fairview | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH G I Malignancy INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-19 19 65 to 12-20 19 65, that (I) (we) last saw the deceased alive on 12-20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Roger Theodore | | | 23B. DATE SIGNED 12-20-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Roger Theodore | | | 23D. ADDRESS 1514 Division Street | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | |
| 24D. LOCATION BALLO | | 24E. (City, town, or county) Md. | | 24F. (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR MORTON & DYETT | |
| | | | | ADDRESS 1701 Laurens | |

1994年 4月 29日 星期四

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------|--|----------------------------|--|--|
| BIRTH NO. 65 13017 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 49-38-62 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 65 13017 | |
| 1. NAME OF DECEASED (Type or Print) Strickland, Annie | | 2. DATE AND HOUR OF DEATH 12/18/65 8:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Dohas Hopkins Hospital | | A. STATE B. COUNTY Maryland 9-08 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2102 Homewood Ave. | | | |
| 5. SEX F | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W. | 8. DATE OF BIRTH 3-1-08 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Richmond, VA. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME WILLIAM BRUNSON | | | |
| 14. MOTHER'S MAIDEN NAME Daisy Holt | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Sallie Miller 2412 Arunah Ave | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) cardiac arrest (B) probable myocardial infarct (C) arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/18/1965 to 12/18/1965, that (I) (we) last saw the deceased alive on 12/18/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles T. Kaelber | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) CHARLES T. Kaelber | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-23-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary | |
| 24D. LOCATION A. A. Co. Md. | | 24E. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | | |
| 24F. NAME OF REGISTRAR R. A. E. Johnson | | 24G. FUNERAL DIRECTOR Morton Dye | | | |
| 24H. ADDRESS 1701 LAURENS ST. | | | | | |

2-1-08

Richmond, Va.

Lat. & Long.

Richmond, Va.

P200

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 13018

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 13018

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEONARD L. PAGE

2. DATE AND HOUR PRONOUNCED DEAD

12-20-65

8:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1606 N. WASHINGTON STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1606 N. Washington Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12-15-1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Leonard Page

14. MOTHER'S MAIDEN NAME

RENA HARRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

217-01-9801

17. INFORMANT

ADDRESS

Mrs. Alice Page. 1606 N. Washington

18.

153.8

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of colon with metastasis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐

NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-20-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-22-65

23C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION

(City, town, or county)

A.A. Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

MORTON & DYETT - 1701 LAURENS

ADDRESS

VALLEY

12-12-1904

John M.

4th Floor

Mr. J. H. H. H.

Resident 12-12-1904 MT. Colvard

A. A. Co

M. H.

Mountain 12-12-1904

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **65 13019**

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) George J. Thornton | | 2. DATE AND HOUR OF DEATH 12-20-65 6:10 P <small>M.</small> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Seton Psychiatric Institute | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-11 | | | |
| 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | | 8. DATE OF BIRTH 6-20-1891 | | 9. AGE (In years lost birthday) 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive - Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Oil Company | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME William W. Thornton | | | | 14. MOTHER'S MAIDEN NAME Agnes Roache | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 216-03-8231 | | 17. INFORMANT ADDRESS Hospital Record | | | |
| 18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Chronic Brain Syndrome with Cerebral Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH 4 years | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized and Cerebral Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH 4 years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from July 2, 1963 to December 20, 1965 , that (we) lost saw the deceased alive on December 20, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William A. King | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec. 20, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) William A. King | | 23D. ADDRESS M.D. 6420 Reisterstown Road, Baltimore, Maryland | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/1965 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR & ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13120 | |
|---|------------------|--|---------------------------------|---|---|
| BIRTH NO. 65 13120 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) B. IRENE B. ENY | | 2. DATE AND HOUR OF DEATH 12/21/65 4:35 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP | | A. STATE MARYLAND B. COUNTY 9-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) 1505 SHADYSIDE AVE ROAD | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED MARRIED, DIVORCED (specify) | 8. DATE OF BIRTH 9/12/90 | 9. AGE (In years lost birthday) 75 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 13. FATHER'S NAME WILLIAM WICKARD 22044-3958 | | 14. MOTHER'S MAIDEN NAME ELIZABETH MORGARDT | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK | | 16. SOCIAL SECURITY NO. UNK | | 17. INFORMANT ADDRESS KISS VIRGINIA VOGEL SPA | |
| 18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO Carcinoma of colon | | | |
| | | (C) with metastases | | see | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 11/13/65 to 12/21 19 65 , that the (we) last saw the deceased alive on 12/21 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert N. Whitlock | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT N. WHITLOCK | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Removal | | 24B. DATE 12/24/1965 | | 24C. NAME OF CEMETERY or CREMATORY Rose Hill | |
| | | | | 24D. LOCATION (City, town, or county) (State) Cumberland Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |

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MARK AND
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MD

LEONARD WICKARD
F W
HARRISON

MISS VIRGINIA WOOD
MISS VIRGINIA WOOD

WILLIAM WICKARD
WICK

Yes

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12/12/80

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

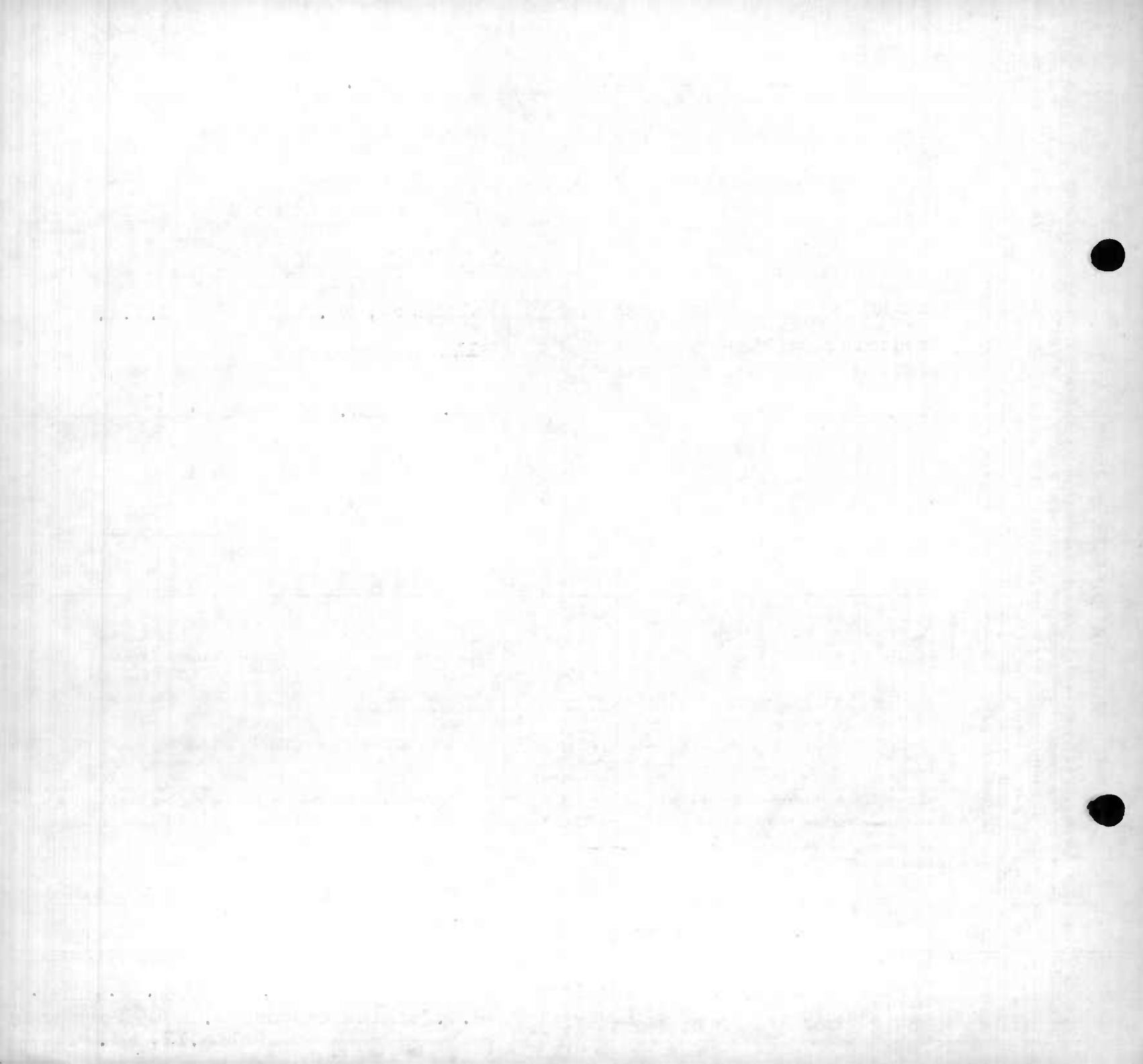
| | | | | | |
|--|--------------|--|-------------------------------|---|---|
| BIRTH NO. 65 13021 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13021 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FAIRALL, Mrs Anna DUSHANE | | 2. DATE AND HOUR OF DEATH 12-20-1965 11:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-38 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION MONTBELLO STATE HOSPITAL | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 1110 E. BELVEDERE AVE. | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 6-28-1898 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME WILLIAM THOMAS | | 14. MOTHER'S MAIDEN NAME DUSHANE ANNE CAROLINE LOGAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No | |
| 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT CAMPBELL D. FAIRALL | | ADDRESS 1110 E. BELVEDERE AVE BALTIMORE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.01 | | CAUSE OF DEATH (A) CEREBRAL THROMBOSIS E DUE TO (B) HEMIPLEGIA DUE TO (C) ARTERIO-SCLEROTIC HEART DISEASE | | INTERVAL BETWEEN ONSET AND DEATH ABOUT 8 WEEKS YEARS | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-30-1965 to 12-20-1965, that (I) (we) last saw the deceased alive on 12-20-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Zin U. Park | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-20-1965 | |
| 23C. PHYSICIAN'S NAME (Type) ZIN U. PARK | | 23D. ADDRESS M.D. MONTBELLO STATE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/1965 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Olivet | |
| 24D. LOCATION (City, town, or county) Baltimore, | | (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR H.W. Jenkins & Sons Co. | | 25C. FUNERAL DIRECTOR ADDRESS 4905 York Rd. Balto. 12, Md. | |

1871-1872

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 13022</u> | |
|--|---------------------|--|--------------------------------------|--|--|
| BIRTH NO. <u>65 13022</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Ella May Hartzell</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 2. DATE AND HOUR OF DEATH <u>Dec. 20, 1965</u> <u>10³⁰ P.</u> M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Gould Nursing Home</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Towson</u> | | | |
| 90 | | D. STREET ADDRESS (If rural, give location) <u>7124 Heathfield Road</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>1/19/1883</u> | 9. AGE (In years last birthday) <u>82</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Frederick Collier</u> | | 14. MOTHER'S MAIDEN NAME <u>Ella Bradburn</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Harry M. Burkhardt</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.14-260 X</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Myocardial Infarction</u> DUE TO (B) <u>Arteriosclerotic C-V Disease</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>10 yrs.</u> <u>?</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Diabetes mellitus</u> | | <u>?</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January 1965</u> to <u>December 1965</u> , that (I) (we) last saw the deceased alive on <u>December 19, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>A. Allen Spier</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/21/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>A. Allen Spier</u> | | 23D. ADDRESS <u>1501 Pentridge Road</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/23/1965</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn</u> | |
| 24D. LOCATION <u>Woodlawn, Balto. Co., Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.</u> | | | |



65 13323

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13023

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THEODORE R. SNOWDEN

2. DATE AND HOUR PRONOUNCED DEAD

12-20-65

11:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2020 Greenmount Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)~~MARRIED~~ Widowed

8. DATE OF BIRTH

May 1, 1903

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-10-9725

17. INFORMANT

ADDRESS

Carman Thomas 1714 W. Lafayette Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-20-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23/65

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 22 1965

Robert R. Fisher

George H. Fisher 1348 N. Calhoun St.

WALLINGFORD

RECEIVED MAY 1 1951

URGENT

SIC-10-0755 JAMES THOMAS WILSON

McArthur

15/23/51 10:10 AM 10:10 AM 10:10 AM

65 13021

BALTIMORE CITY HEALTH DEPARTMENT

65 13024

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ISABEL

HILLIAN

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1965

12:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED

FULL NAME OF DECEASED IN HOSPITAL OR INSTITUTION
ADDRESS OR LOCATION

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1810 Presbury Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 7, 1919

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Robert Dawson Dorsey

14. MOTHER'S MAIDEN NAME

Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-12-0020 Tola Hillian 1810 Presbury St.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/24/65

23C. NAME OF CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

24B. NAME OF REGISTRAR

Robert E. Jordan, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

George A. Kline 1348 N. Calhoun St.

Reg.No. B 54562 for registrant

Fa: ⁿRobert Dorsey
Mo: Mary Brown

41-54-62 IB

65 13025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 13025

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Gertrude Bramhall

2. DATE AND HOUR OF DEATH

12/20/65 10⁰³ P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4940 Eastern Avenue-Baltimore, Md.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9-10-1865

9. AGE (In years
lost birthday)

100

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Daniel Baker

14. MOTHER'S MAIDEN NAME

Lydia Bitzer

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 Eastern Avenue

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pneumonia

12 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

Poor Responsiveness
ASCVD

1 week

(C)

?

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/18 1964 to 12-20 1965,
that (I) (we) lost saw the deceased alive on 12-20 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Alan E. Oestrich

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-20-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Alan E. Oestrich

M.D.

23D. ADDRESS

BCH-4940 Eastern Avenue, Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-23-1965

24C. NAME OF CEMETERY or CREMATORY

Union

24D. LOCATION

Lovettsville,

Va.

25A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

25B. NAME OF REGISTRAR

Robert E. Johnson

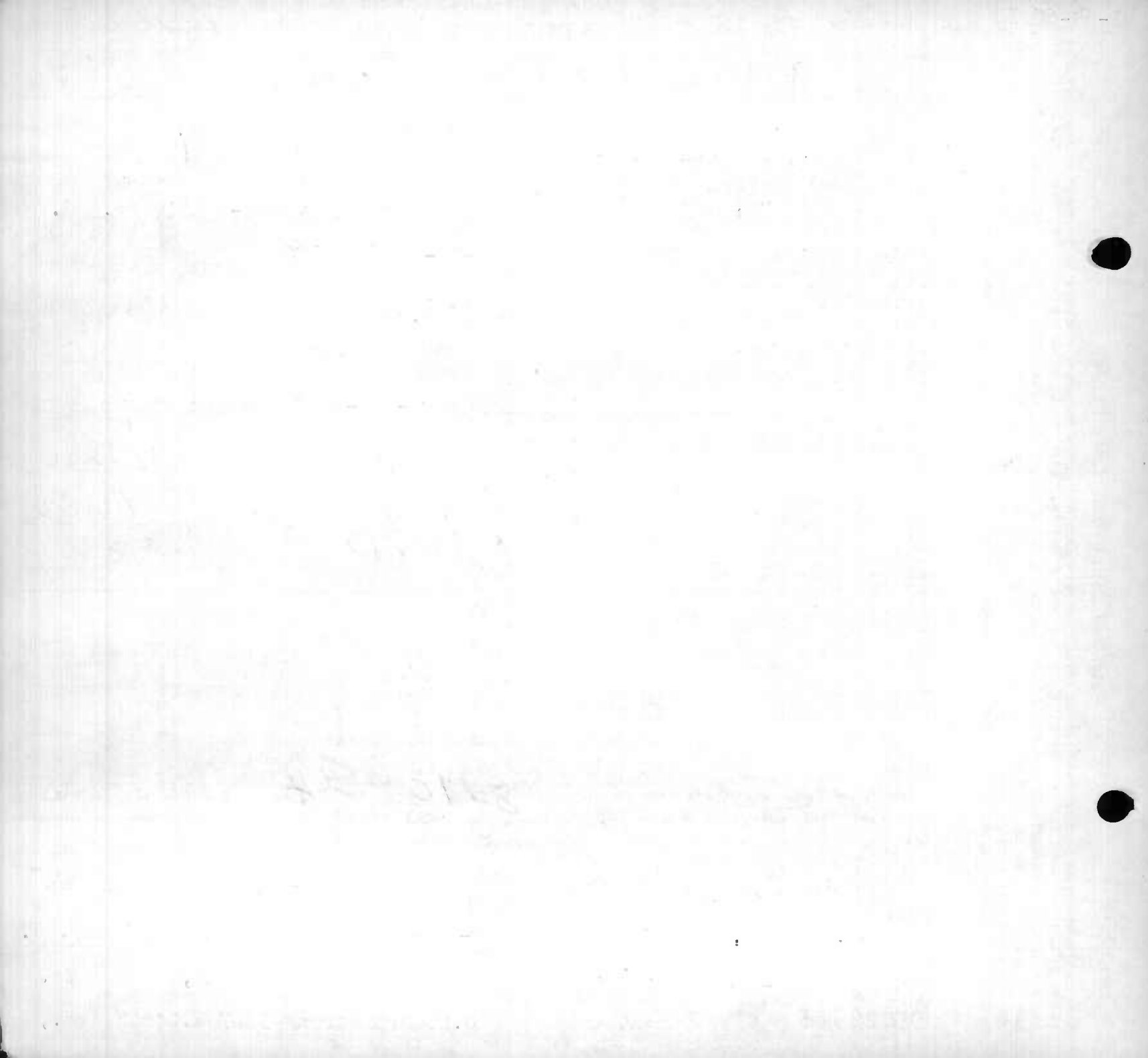
25C. FUNERAL DIRECTOR

G. Howard Strong 3207 W. North Ave.,

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

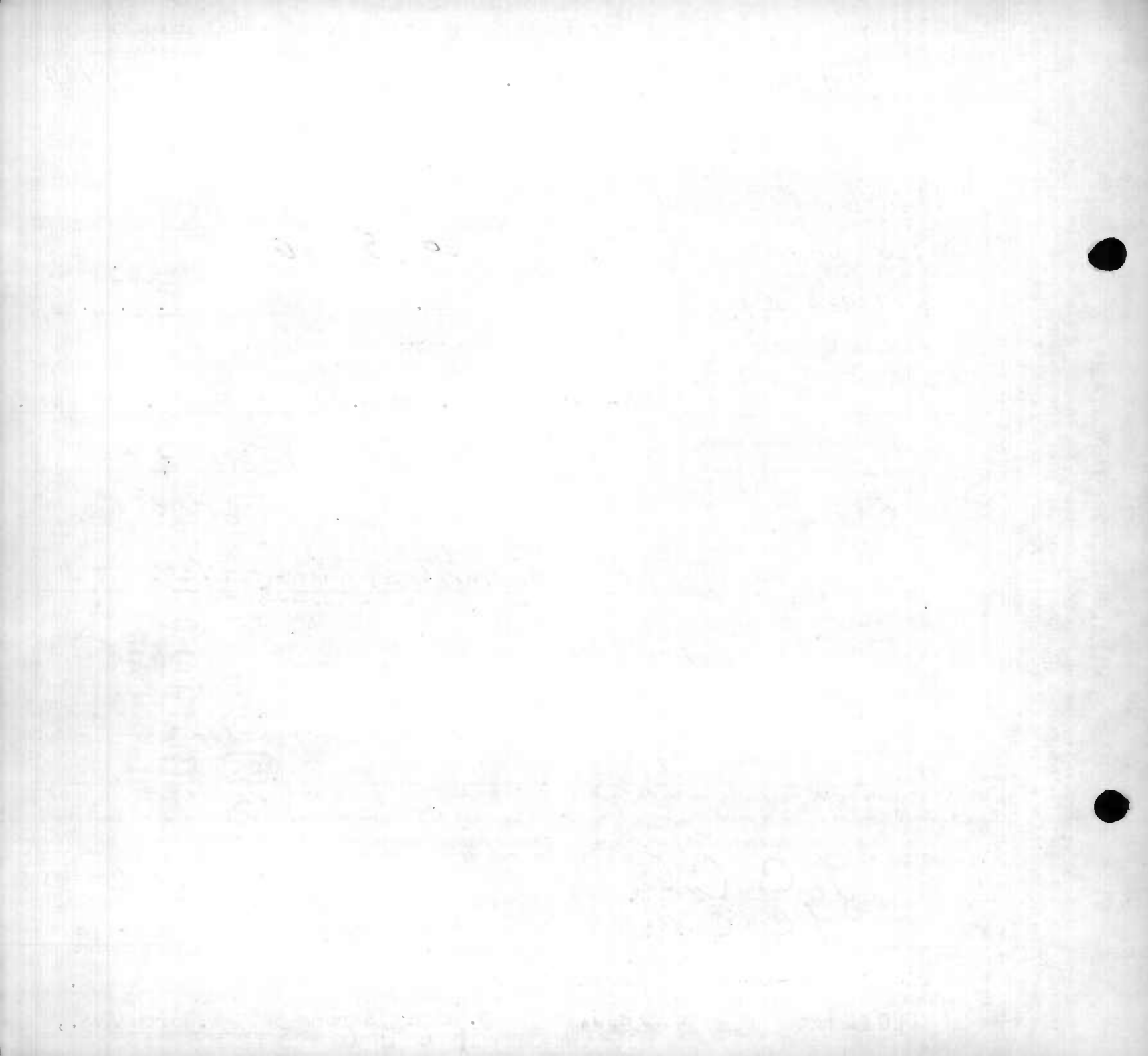
FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13026 | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. 65 13026 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) W. Whitmore William J. | | 2. DATE AND HOUR OF DEATH 19-Dec-65 9:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5412 W North Ave | | |
| 5. SEX MALE | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-30-85 | 9. AGE (In years lost birthday) 80 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME Joshua Whitmore | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-03-5449 | | 17. INFORMANT Mrs. Rose M. Whitmore ADDRESS 5412 W. North Ave. | |
| 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident | | | INTERVAL BETWEEN ONSET AND DEATH 29 days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (B) Cerebral Vascular Accident 4 YEARS (C) Arteriosclerotic, Cardio Vascular disease - Pylorospasm acute + chronic - Bronchopneumonia upper lobe | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) ✓ | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that if (this hospital) attended the deceased from 20 Nov 19 65 to 19 Dec 19 65 , that if (we) last saw the deceased alive on 19-Dec-19 65 and that in if (our) opinion death occurred on the date and hour and from the causes stated above. if (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. C. Cullis | | | | 23B. DATE SIGNED 19-Dec-65 | |
| 23C. PHYSICIAN'S NAME (Type) J. C. Cullis | | 23D. ADDRESS MARYLAND GENERAL Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-22-1965 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR G. Howard Strong ADDRESS 3207 W. North Ave., | | | |



65 13827

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13027

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

SIMMONS

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1965

5:42 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1725 Washington Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 16, 1898

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Norfolk, VA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Davis

14. MOTHER'S MAIDEN NAME

Mary Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Eloza Simmons

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-24-65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

24B. NAME OF REGISTRAR

Robert E. Jenkins, M.D.

24C. FUNERAL DIRECTOR

Elroy O. Wilson 1000 Brantley Ave.

ADDRESS

WALLER FORTGE

RASTON TOWN

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 13028**BIRTH NO. **65-13479**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

WATSON, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

December 20, 1965

8:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1035 Orleans Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Baby

8. DATE OF BIRTH

August 2, 1965

9. AGE (In years
last birthday)10 Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

4

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Baby

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Charles Watson, Sr.

14. MOTHER'S MAIDEN NAME

Sandra Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Bronchopneumonia

(A) ~~Interstitial Pneumonitis~~

DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHII
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/21/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-24-1965

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cent

23D. LOCATION

Brooklyn

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

24B. NAME OF REGISTRAR

Robert E. Sullivan

24C. FUNERAL DIRECTOR

Chas. J. Wilson 1000 Brantley Ave

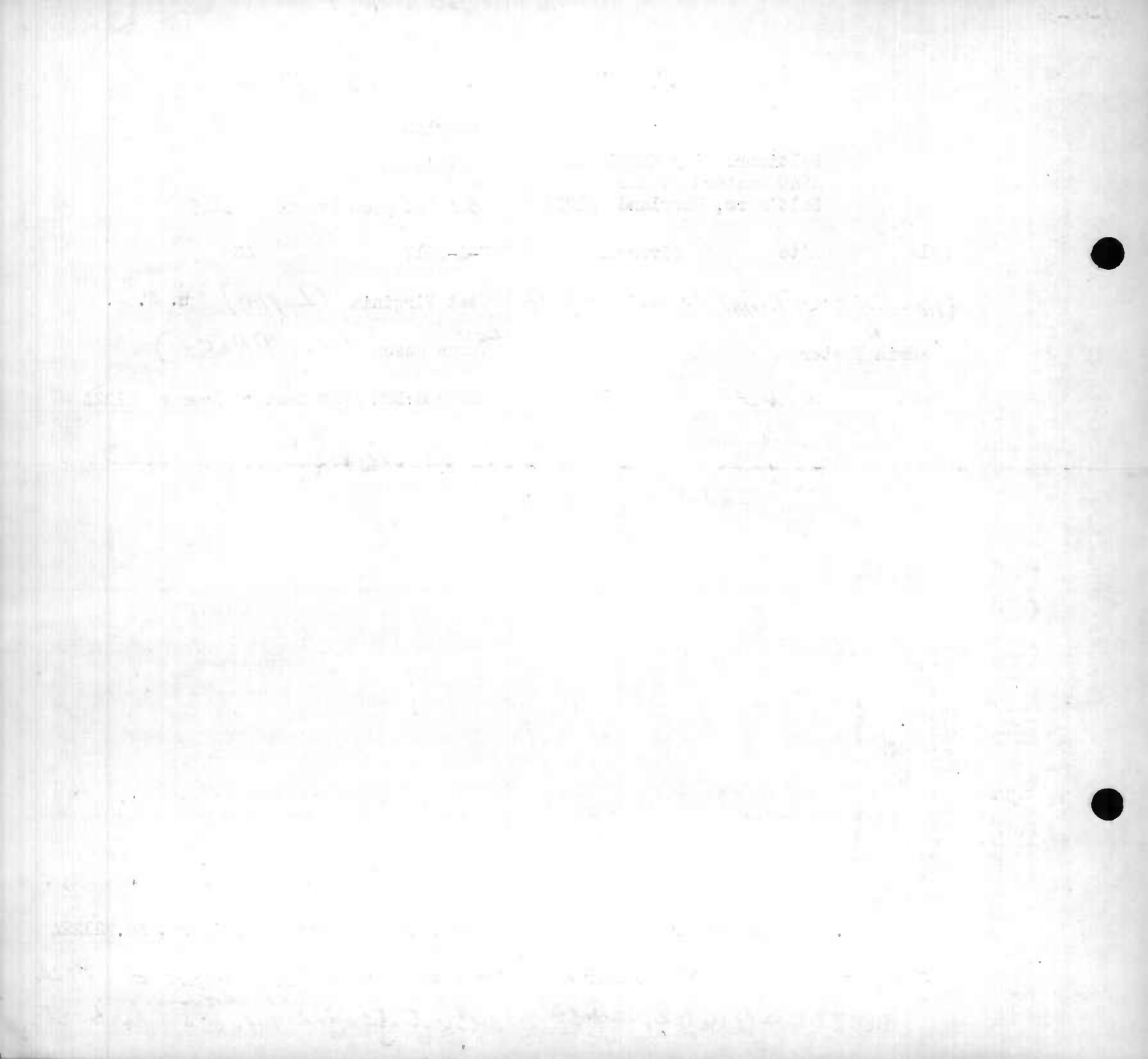
ADDRESS

VALLEY FORCE

AG. OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| F-230 | | BALTIMORE CITY HEALTH DEPARTMENT | |
|--|----------|--|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| Thomas D. Foster, Sr. | | 12-19-65 6 ⁴⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland Baltimore | |
| 5. SEX | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| Male | White | Baltimore | |
| 6. RACE | | D. STREET ADDRESS (If rural, give location) | |
| White | Divorced | 524 Patapsco Avenue 21225 | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | E. DATE OF BIRTH | |
| Divorced | | 9-4-1917 | |
| 8. AGE (In years lost birthday) | | 9. AGE (In years lost birthday) | |
| 48 | | 48 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| CLERK-FREIGHT TRUCKING CO. | | West Virginia, (Logan) | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| CLERK-FREIGHT TRUCKING CO. | | U. S. A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Edwin Foster | | Verna Beach (Nee PRICE) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | ? | |
| 17. INFORMANT | | ADDRESS | |
| RECORDS: BCH | | 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | |
| ANTECEDENT CAUSES | | (B) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| Chronic obstructive Pulm. Disease | | mos. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 0 | | NO. | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| NO. | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-9-65 to 12-19-65, that (I) (we) last saw the deceased alive on 12-19-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| Kenneth Tucker | | 12-19-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| Dr. Kenneth Tucker | | 4940 Eastern Avenue Baltimore, Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Burial | | 12-21-65 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| GLEN HAVEN | | GLEN BURNIE Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| DEC 22 1965 | | Curtis Evans | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| Curtis Evans | | 1400 S. Charles St. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 6513030

BIRTH NO.

M.E. CASE NO. 3030

1. NAME OF DECEASED
(Type or Print)

WILLIAM WEIHER

2. DATE AND HOUR PRONOUNCED DEAD

12/2/65 6:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

704 E. Baltimore St.

704 E. Baltimore St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Abscess forming pyelonephritis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Warner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/3/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

DEC 22 1965

23C. NAME OF CEMETERY & CREMATORY

23D. LOCATION

(City, town or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

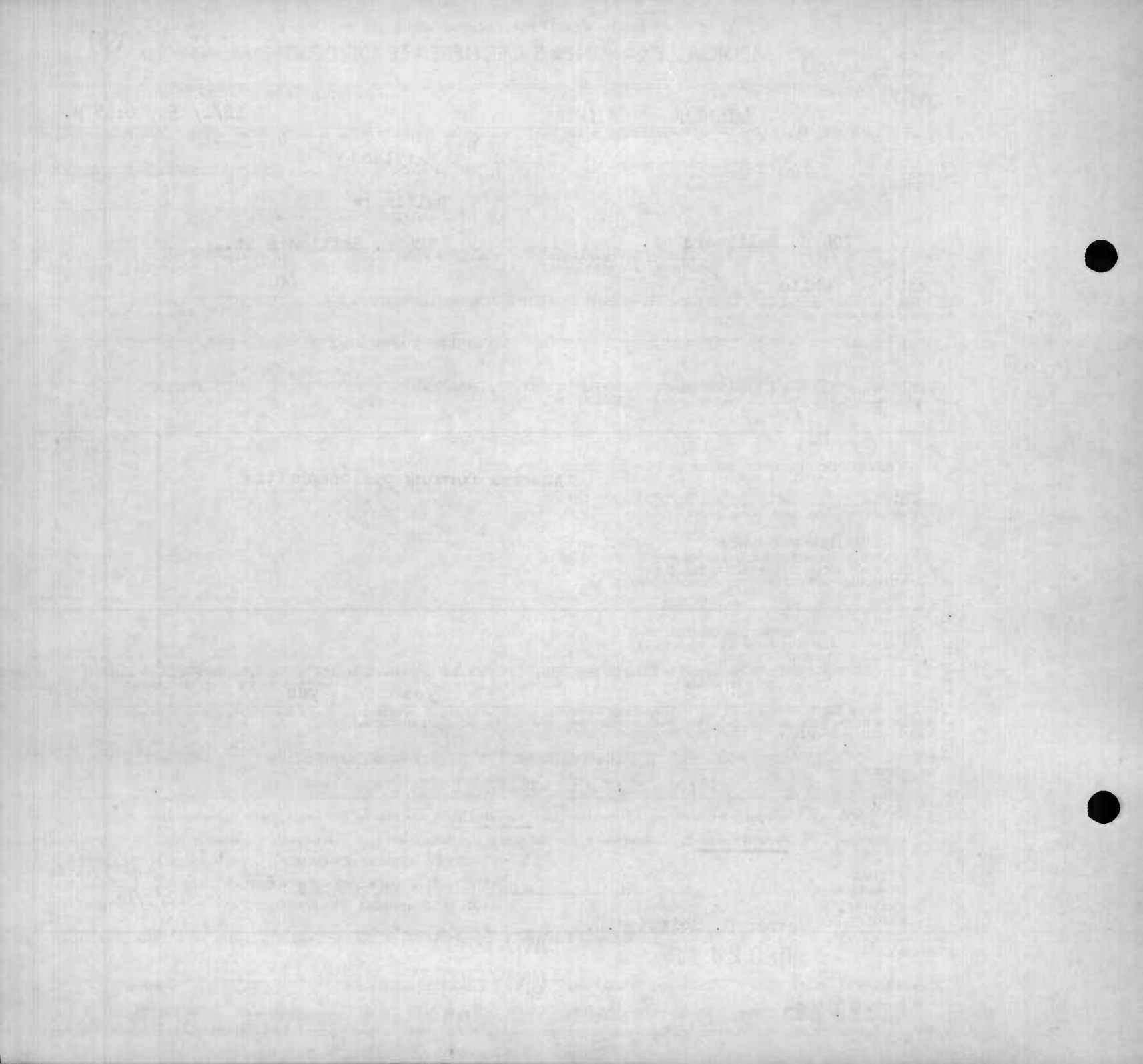
24C. FUNERAL DIRECTOR

ADDRESS

DEC 22 1965

DEC 22 1965

MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 65 13031 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13031 | |
|--|---------|--|------------------|--|------------------------|--|------------------------------|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| SYLVAN WATERMAN | | | | 12-11-65 12:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| MARYLAND GENERAL HOSPITAL | | | | MARYLAND 11-01 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | MT ROYAL HOTEL MT ROYAL & CALVERT ST | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. CITIZEN OF WHAT COUNTRY? |
| M | W | WIDOWED | 2-22-89 | 76 | | | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | VIRGINIA | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| MOSES J. WATERMAN | | | | UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | SELF ON ADMISSION | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | Pulmonary embolus | | | |
| ANTECEDENT CAUSES | | | | ACUTE MYOCARDIAL INFARCTION | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | HYPERTENSIVE CARDIOVASCULAR DISEASE | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | FRACTURE, HIP, LEFT | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 3-12-8-65 | | FRACTURE, HIP LEFT | | NO | | YES 11-01 | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | MT. ROYAL HOTEL | | MT ROYAL HOTEL MT ROYAL & CALVERT ST. | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| JUNE 1965 | | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | FALL in room | | | |
| 22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 30 1965 to DECEMBER 11 1965, that (I) (we) last saw the deceased alive on DECEMBER 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| ROSAIRIO D. BELLO | | | | | | 12-11-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR | | ADDRESS | |
| ROSAIRIO D. BELLO | | MARYLAND GENERAL HOSPITAL | | UNIVERSITY MEDICAL SCHOOL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY | | 24D. LOCATION (City, town, or county) (State) | |
| | | DEC 22 1965 | | ANATOLY BOARD OF MARYLAND | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 22 1965 | | J. E. JONES | | MORTUARY SERVICE - BCMD | | | |

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---|--|--|--|--|--|--|--|
| 65 13032 | | | | | | 65 13032 | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| PETER U. WEST | | | | December 4, 1965 3:45 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE New Jersey B. COUNTY Camden | | | |
| Sinai Hospital | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Camden | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH | |
| Male | | White | | | | 9. AGE (In years last birthday) 60 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Arteriosclerotic Cardiovascular Disease. DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/5/65 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| | | | | DEC 22 1965 | | UNIVERSITY MEDICAL SCHOOL | |
| 24A. DATE REC'D BY HEALTH DEPT. | | | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| DEC 22 1965 | | | | Robert E. [Signature] | | MORTUARY SERVICE - BCHD | |

VALLEY FORGE
PIT CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

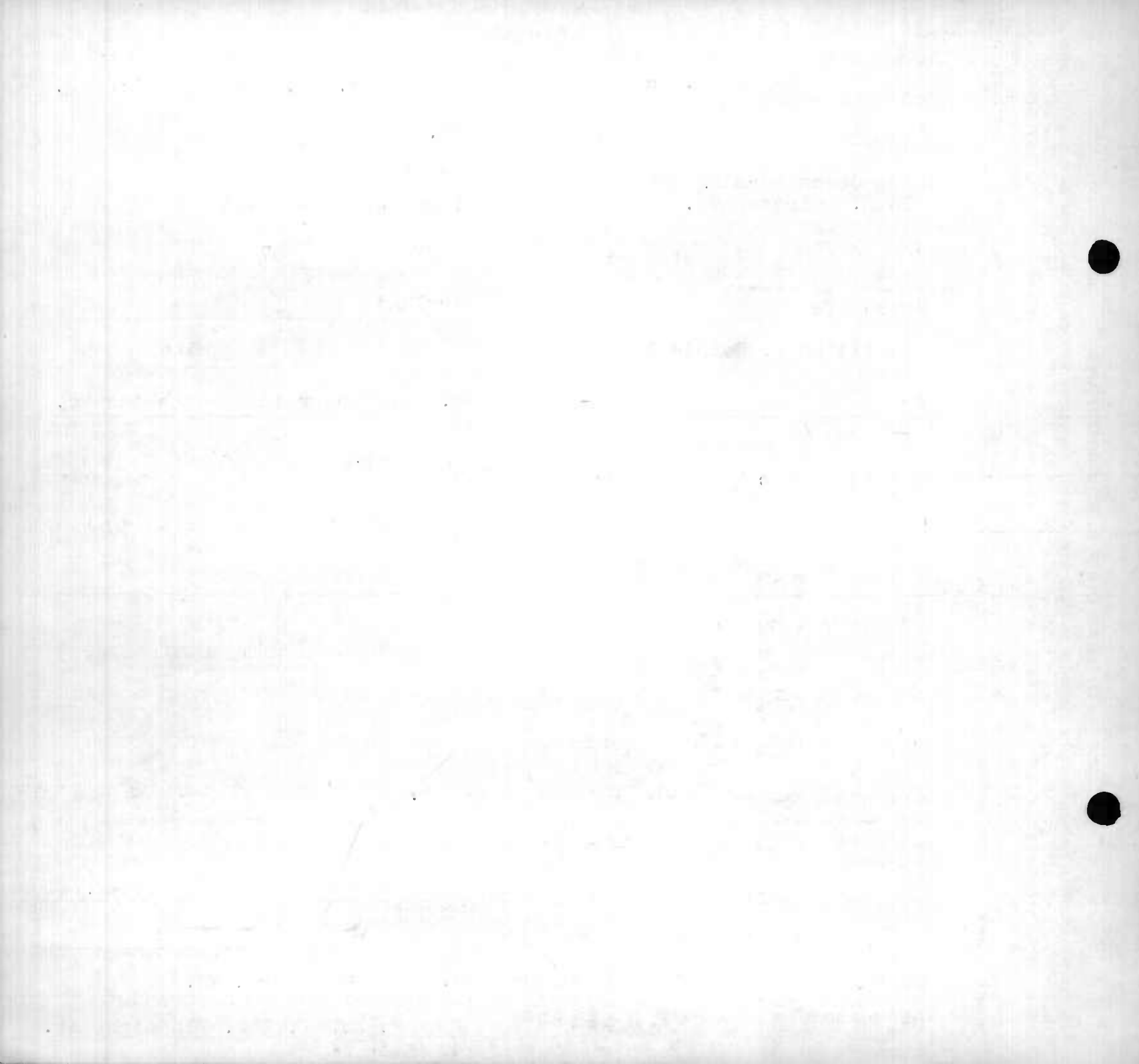
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13033 | |
|---|----------------------|--|------------------------------------|---|---|
| BIRTH NO. 65 13033 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Elsie Beall | | 2. DATE AND HOUR OF DEATH 12-16-65 11:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp. | | A. STATE Maryland B. COUNTY 23-02 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #1216 | | | |
| | | D. STREET ADDRESS (If rural, give location) 16 East Fort Ave. | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 4-25-98 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Jim Smoot | | | |
| 14. MOTHER'S MAIDEN NAME Fannie May Higgs | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 219-03-0415 | | 17. INFORMANT ADDRESS MR. JOHN BEALL 6840 BELCLARE RD. | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Left Cerebral Thrombosis | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) ASK MD. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (B) _____ | | | |
| (C) _____ | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that this (this hospital) attended the deceased from 12-14 19 65 to 12-16 19 65 , that we (we) lost saw the deceased alive on 12-16 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. H.J. Hargrave | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-17-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS South Baltimore General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY CEDAR HILL CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | | |
| 25B. NAME OF REGISTRAR John F. Denny, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 715 LIGHT | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13034 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13034 | |
|---|--|--|--|---|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | BESSIE D. McDORMAN | | Dec. 18, 1965 11:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | Md. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| Long Green Nursing Home 115 E. Melrose Ave. | | | | Baltimore | | D. STREET ADDRESS (If rural, give location) | |
| 1522 Kennewick Road | | | | 1522 Kennewick Road | | 902 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| F | | W | | Widowed | | 6/18/78 | |
| 9. AGE (In years lost birthday) | | 10. AGE (In years lost birthday) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 87 | | 87 | | Maryland | | White | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| Housewife | | | | Housewife | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William F. Dashiell | | | | White | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | - | | Mrs. Mary Denny 1522 Kennewick Rd. | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) DUE TO | | 10 min. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | 5 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| D | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from Dec 19 52 to Dec 18 19 65, that (I) (we) last saw the deceased alive on Dec 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| W. R. Freeman Jr. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 12/20/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| W. R. Freeman Jr. | | 11 W. 29 St. | | Burial | | 12/21/65 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| Lorraine Park Cem. | | Baltimore, Md. | | DEC 22 1965 | | John F. Denny, Inc. | |
| 25C. FUNERAL DIRECTOR ADDRESS | | 25D. NAME OF REGISTRAR | | 25E. FUNERAL DIRECTOR ADDRESS | | 25F. NAME OF REGISTRAR | |
| JOHN F. DENNY, INC. 715 Light St. | | John F. Denny, Inc. | | John F. Denny, Inc. | | John F. Denny, Inc. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

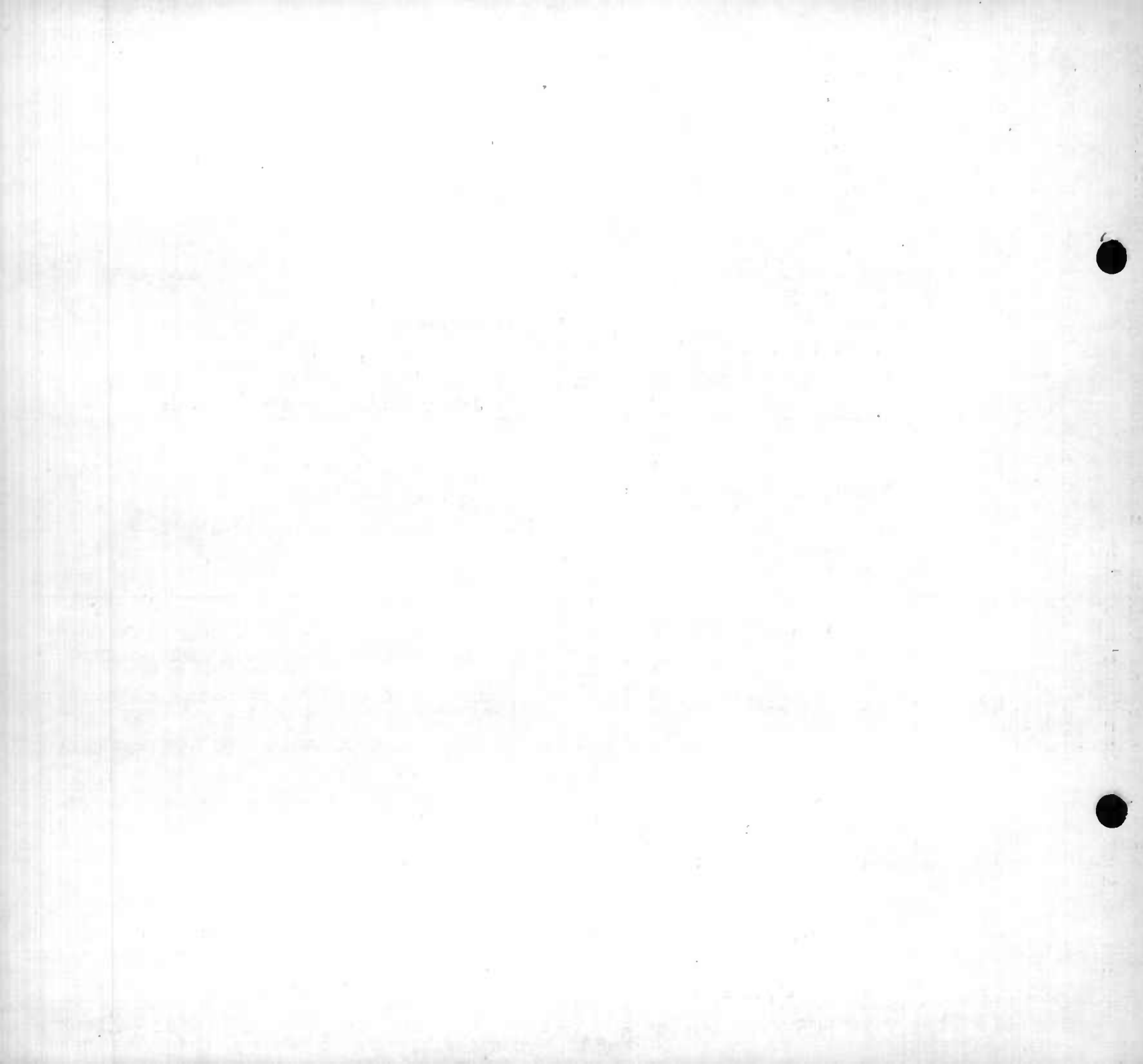
| | | | | | |
|--|---------------------|--|--|--|---|
| BIRTH NO. 65 13035 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13035 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type in Print) LESZCZYNSKI, KATHERINE | | 2. DATE AND HOUR OF DEATH 12-18-65 2:00 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 50. BALTO. GEN HOSP | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 50. BALTO. GEN HOSP | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21230 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1148 Hull St. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 12-29-1883 | 9. AGE (In years lost birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? Poland |
| 13. FATHER'S NAME Poniewaz | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS John Leszczynski 1148 Hull St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E903.6 | | CAUSE OF DEATH Myocardial infarct, Ant-C-3 hrs. Jewel hip nailing, phenobarb. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 1-12-17-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystectomy for calculi | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Church | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore Holy of Spirit Church | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 12-5-65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Slipped and fell | |
| 22. I certify that (this hospital) attended the deceased from 12-5-65 19 to 12-18-65 1965, that (we) last saw the deceased alive on 12-18-65 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Francis J. [Signature] M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-19-65 | |
| 23C. PHYSICIAN'S NAME (Type) NARCISO A. DE BORJA | | 23D. ADDRESS 50. Balto. Gen Hosp | | 1213 Light St. Balto. Md 21230 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS Charles L. Stevens Funeral Home, Inc. 1506 E. Fort Avenue | | | |

THE UNIVERSITY OF CHICAGO

The body of Marion Huber was released to The Johns Hopkins Hospital non-med
Examiner's Office
by the Medical
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

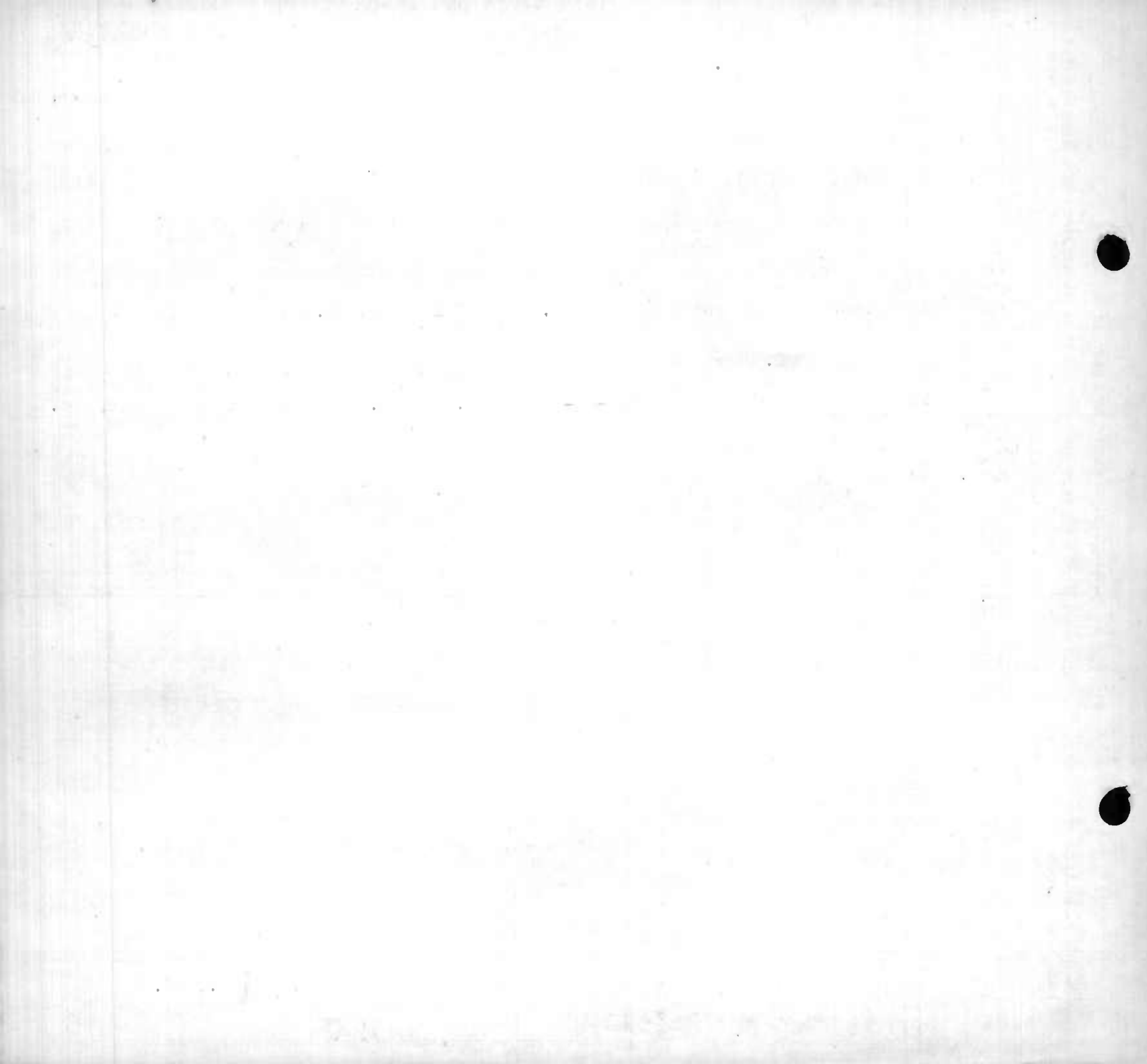
| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. 65 13036 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13036 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| HUBER, MARION M. | | 12/21/65 145 A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M. | |
| THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | FLORIDA, SARASOTA | | 8. DATE OF BIRTH 2/15/02 9. AGE (In years last birthday) 63 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) SARASOTA | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| | | D. STREET ADDRESS (If rural, give location) 722 Indian Beach Lane | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 13. FATHER'S NAME WINFIELD MAYO | | 14. MOTHER'S MAIDEN NAME BRONOLD, MARY | | 11. BIRTHPLACE (State or foreign country) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | 17. INFORMANT Johns Hopkins Hospital Records | | ADDRESS | |
| | | | | | |
| 18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Increased Intracranial Pressure DUE TO (B) Glioblastoma multiforme DUE TO (C) | | 14 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | C Temporal craniotomy | | 16 hours | |
| 19A. DATE OF OPERATION 3/12/20/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor. | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (N) (this hospital) attended the deceased from 12/14 1965 to 12/21 1965, that (N) (we) last saw the deceased alive on 12/21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles Burton | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) CHARLES BURTON, M.D. M.D. | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL, 601 N. Broadway. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 12/21/1965 | | 24C. NAME of CEMETERY or CREMATORY Harrison, Ohio | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | | | Baltimore, Md. 21217 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

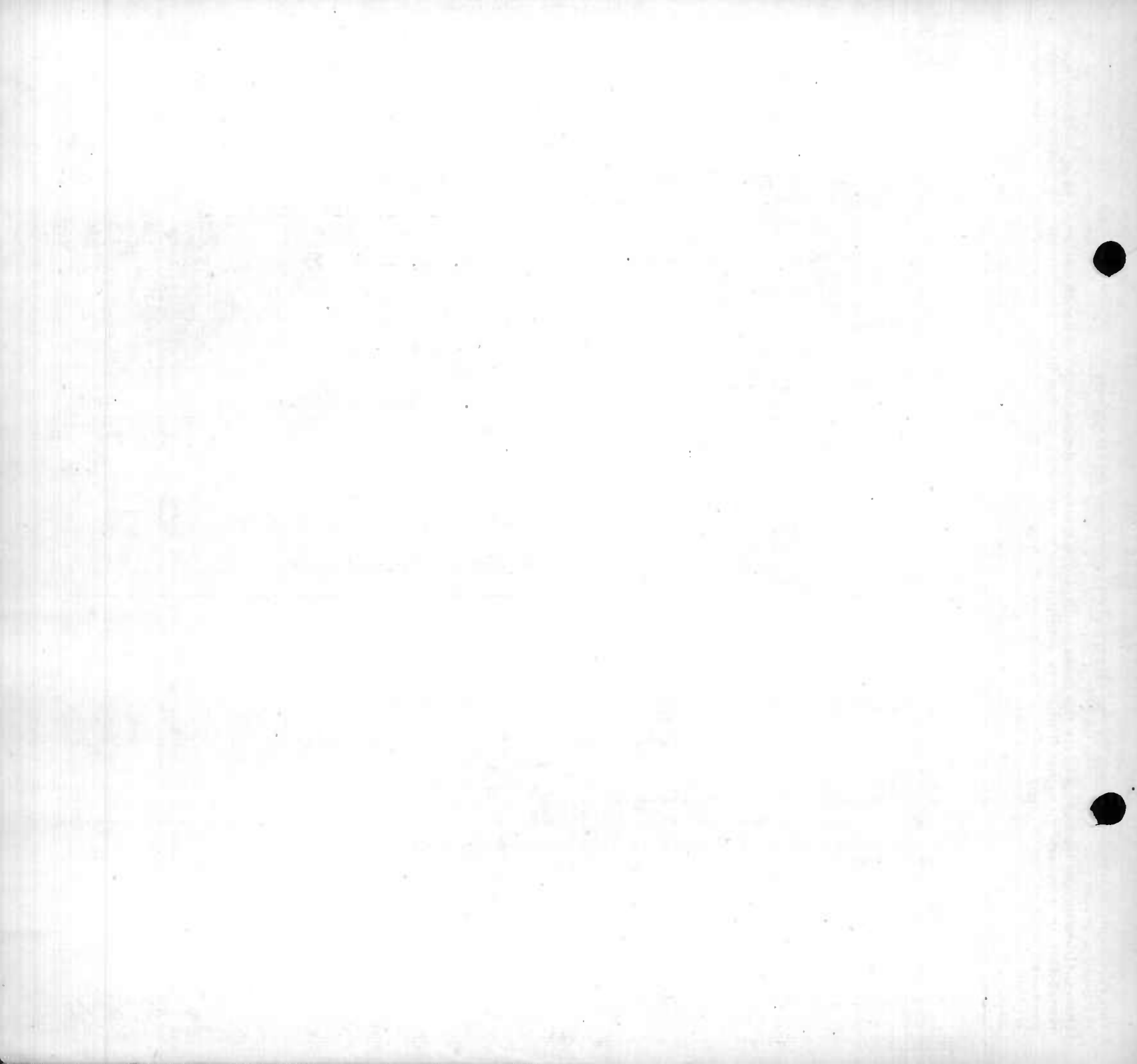
| BIRTH NO. 65 13037 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13037 | |
|--|------------------|---|---|---|---|--|------------------------------|-------------------------|--|
| 1. NAME OF DECEASED (Type or Print) OWEN S. BENNETT | | | | 2. DATE AND HOUR OF DEATH 12-20-65 8.15 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) SPARROWS POINT D. STREET ADDRESS (If rural, give location) 904 E. STREET | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8-16-03 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk | | | 10B. KIND OF BUSINESS OR INDUSTRY Beth Steel Corp. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME JOSEPH O. BENNETT | | | | 14. MOTHER'S MAIDEN NAME MAE HICKS | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-07-1338 | | 17. INFORMANT Mrs. Ruth W. Bennett | | ADDRESS 904 East Street Sparrows Point, Md. | | | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>Oat Cell Carcinoma of Lung</u> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertension, unilateral renal disease</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>12/20/65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> 19 <u>65</u> to <u>12/20</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Allen Johnson</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/20/65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) ALLEN JOHNSON | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/1965 | | 24C. NAME of CEMETERY or CREMATORY Oaklawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Wm. A. Johnson & Sons</u> | | ADDRESS <u>Baltimore, Md. 17 North & Pe. av.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

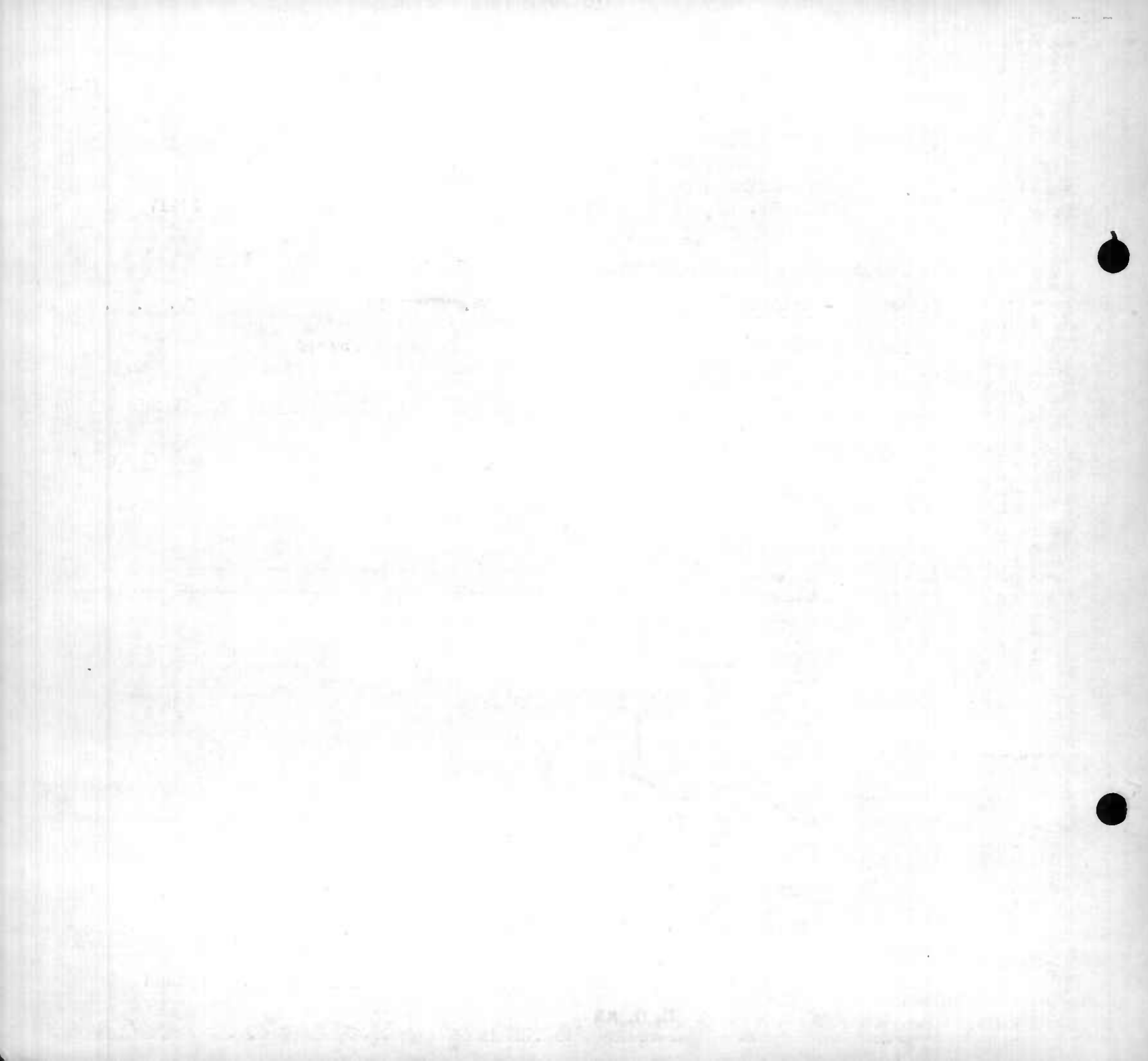
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13038 | |
|--|------------------|---|-----------------------------------|--|---|
| BIRTH NO. 65 13038 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Alice Hamburger | | 2. DATE AND HOUR OF DEATH December 20, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3714 Glengyle Avenue 15 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3714 Glengyle Avenue Baltimore, Maryland 21215 | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Aug. 20, 1870 | 9. AGE (In years last birthday) 95 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Meyer Hamburger | | 14. MOTHER'S MAIDEN NAME Julia Coblens | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Schlossberg same address as above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 442X1 UREMIA | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO NEPHRO SCLEROSIS ARTERIO SCLEROSIS | | INTERVAL BETWEEN ONSET AND DEATH 2 months | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC HEART DISEASE | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 1960 to Dec. 19 1965, that (I) (we) last saw the deceased alive on December 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard D. Nahan | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD D NAHAN | | 23D. ADDRESS M.D. 1010 SAINT PAUL STREET | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/1965 | | 24C. NAME OF CEMETERY or CREMATORY Oheb Shalom Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR Wm. J. Fisher + Son | | 25C. FUNERAL DIRECTOR Baltimore, Md. 21217 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| BIRTH NO. 65 13039 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. _____ | |
|--|------------------|---|------------------------------|--|-----------------------|--|-----------------------------|
| M.E. CASE NO. 65 13039 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Laten Phares</i> | | | | 2. DATE AND HOUR OF DEATH 12/21/65 7:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2315 CALLOW AVENUE 21217 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11-21-95 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) W. VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Roland Phares | | | | 14. MOTHER'S MAIDEN NAME Margaret Bowers | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (A) <i>2 am reg. sepsis</i> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 24° | |
| | | | | (B) <i>Extension from above</i> DUE TO | | yes | |
| | | | | (C) <i>lung infections & COPD</i> DUE TO | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>11-21-65</u> 19 <u>65</u> to <u>12-21-65</u> 19 <u>65</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12-21</u> 19 <u>65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Brian B. Bouton</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) BRIAN B. BOUTON | | | | 23D. ADDRESS BCH 4940 EASTERN AVENUE #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/1965 | | 24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR P. O. A. 2. <i>J. J. ...</i> | | 25C. FUNERAL DIRECTOR Wm. J. ... | | ADDRESS Baltimore, Md. 17 North & Pa. Aves. | |



45-45-79

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 13040

BIRTH NO.

65 13040

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Edward George Smith

2. DATE AND HOUR OF DEATH

December 19, 1965

12:30

P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

227 N. Rose Street 21224

5. SEX

M

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

7-12-1922

9. AGE (In years
lost birthday)

43

If Under 1 Yr.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

INSPECTOR

10B. KIND OF BUSINESS OR INDUSTRY

MARTINS

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

FRANK L. SMITH

14. MOTHER'S MAIDEN NAME

IRENE GETTMAN

15. Was Deceased Ever in U. S. Armed Forces?

YES

W. W. II

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

215-18-0709

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A)
DUE TO(B)
DUE TO

(C)

Pharyngitis

malnutrition

Hemoglobinemia, Angioma, Lymphoma

3 months

1 yr

10 years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Aspiration

1 day

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/15 1965 to 12/19 1965,
that (I) (we) last saw the deceased alive on 12/15 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. George Gey

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

12/19/65

23C. PHYSICIAN'S
NAME (Type)

Dr. George Gey

23D. ADDRESS

M.D. 4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12-23-65

24C. NAME of CEMETERY or CREMATORY

BALTO NAT. CEM.

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Anthony Miller - 2334 Jefferson St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8- 2- 1

10/10/10

10/10/10

10/10/10

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10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

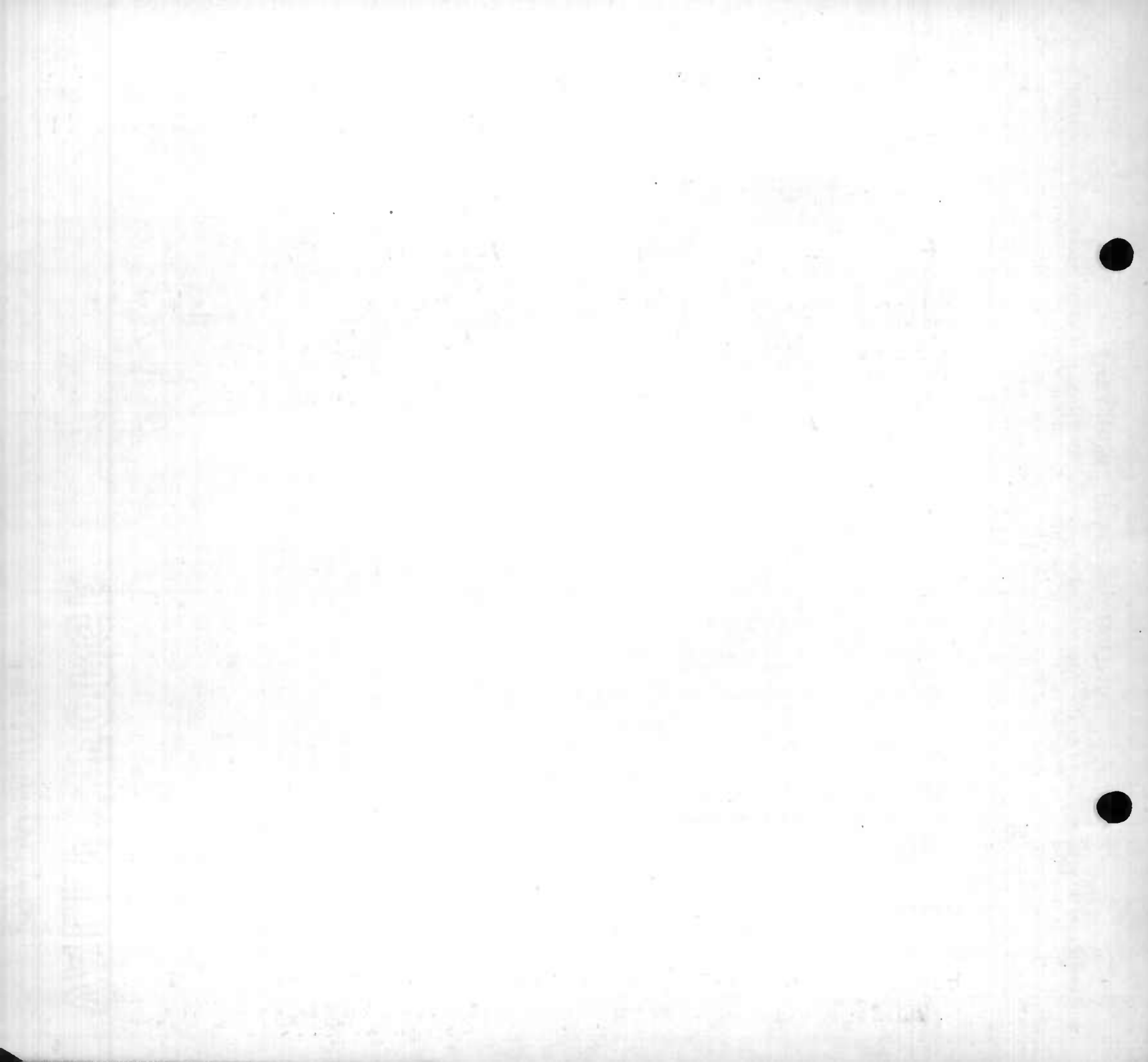
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13041 | |
|---|------------------------|--|---------------------------------------|--|--|
| BIRTH NO. 65 13041 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>John Henry Williams</i> | | 2. DATE AND HOUR OF DEATH <i>December 21 1965 9:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1214 E. Preston St</i> | | A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 53-00</i> | |
| | | D. STREET ADDRESS (If rural, give location) <i>818 I Street, Sparrows Point</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>Nov. 26, 1903</i> | 9. AGE (in years, last birthday) <i>62</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steelworker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Homesville Virginia</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>George Williams</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Taylor</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>217-03-7662</i> | | 17. INFORMANT <i>Patricia Ann Williams</i> ADDRESS <i>818 I Street</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I | | <i>Carcinoma of Stomach</i> | | <i>?</i> | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>Nov. 1964</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of Stomach</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 17 1965</i> to <i>Dec 21 1965</i> , that (I) (we) last saw the deceased alive on <i>Dec 17 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>F. K. Adams</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12-22-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>F. K. ADAMS</i> | | 23D. ADDRESS <i>1222 N. Caroline St Baltimore 13 Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i> | | 24B. DATE <i>Dec 26/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Little Mount Virginia</i> | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i> | |
| 25C. FUNERAL DIRECTOR <i>Miller & Elicker</i> | | 25D. ADDRESS <i>1297, Carroll St</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|------------------------------------|---|--|
| 65 13042 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13042 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mymie Woodley Brown | | 2. DATE AND HOUR OF DEATH Dec 20 1965 6:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Springdale Ave., Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City D. STREET ADDRESS (If rural, give location) 3704 Springdale Ave 15-38 | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-5-11 | 9. AGE (In years lost birthday) 56 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plastic Worker | | 10B. KIND OF BUSINESS OR INDUSTRY Plastic | | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Jacob Woodley | | 14. MOTHER'S MAIDEN NAME Cora Jackson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 228-38-7445 | | 17. INFORMANT Mrs. Mary Jones ADDRESS 1915 W. Fairmount Av | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO CARCINOM, LIVER (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-16-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-9-65 to 12-20-65 that (I) (we) last saw the deceased alive on 6:15 AM 12-20-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Benham G. Constantine M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 12-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) MOISES FRAIMAN M.D. | | | | 23D. ADDRESS LUTHERAN HOSPITAL OF M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY or CREMATORY Little Mount Baptist Ch. Cem Petersburg Va | |
| 25A. DATE RECEIVED BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Cooper Men Chapel Joseph B. Russ ADDRESS 512 N. Carrollton Av | |



The Body of Joseph Sieber was released to The Johns Hopkins Hospital

Non-Med by Dr. Petty 12-17-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

65 13043

BIRTH NO.

65 13043

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Sieber Sr.

2. DATE AND HOUR OF DEATH

12-17-65

10:15 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

927 Abbott Court

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

XXX 10-28-96

9. AGE (In years
last birthday) 69

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Service Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Ketty Buick

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Christaan Sieber

14. MOTHER'S MAIDEN NAME

Theresa Kola

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Naomi Sieber, wife, above

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Myocardial ASCVD

INTERVAL BETWEEN
ONSET AND DEATH

years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Laurence's Curiosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐ Not While
At Work ☐

22. I certify that (I) (~~this hospital~~) attended the deceased from 12-16-1965 to 12-17-1965,
that (I) (~~we~~) lost saw the deceased alive on 12-17-1965 and that in (my) (~~our~~) opinion death occurred on the date
and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE

Nicholas J. Fortuin

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

12-17-65

23C. PHYSICIAN'S
NAME (Type)

Nicholas J. Fortuin

M.D.

23D. ADDRESS

the Johns Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/21/65

24C. NAME of CEMETERY or CREMATORY

Baltimore, Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 22 1965

25B. NAME OF REGISTRAR

R. A. J. Jr.

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

3331 Brems Lane #13

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | | | | | | | | | | | |
|--|--|--------------|--|---|---|------------------------------|--|---------------------------------------|--|---|--|-----------------------------|--|--|
| BIRTH NO. 65 13044 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 13044 | | | | |
| 1. NAME OF DECEASED (Type or Print) SCHEELER, MARGARET | | | | | | | | | | 2. DATE AND HOUR OF DEATH 12-19-65 10:37 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSP BALTIMORE, MD. | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY USA C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 0300 D. STREET ADDRESS (If rural, give location) RT 16 Box 79 Bird River Ro | | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 12-21-86 | | 9. AGE (In years last birthday) 78 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Schuler | | | | | 14. MOTHER'S MAIDEN NAME Mary Fiske | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | |
| 16. SOCIAL SECURITY NO. None | | | | | 17. INFORMANT Mrs Rudolph Fischer 8805 Harford Road | | | | | ADDRESS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Embolic vascular thrombosis (B) Hypertension (C) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days year | | | | | | | | | | 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | | 20A. AUTOPSY? (Yes or No) — | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-17 1965 to 12-19 1965, that (I) (we) last saw the deceased alive on 12-17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE J. C. MARIANO | | | | | | | | | | 23B. DATE SIGNED 12-19-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) J. C. MARIANO | | | | | | | | | | 23D. ADDRESS CHURCH HOME + HOSPITAL BALTIMORE MD. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 12-20-1965 | | | | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | | | |
| 24D. LOCATION Baltimore Co. Md. | | | | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Fisher | | | | |
| 25C. FUNERAL DIRECTOR Leland E. Johnson | | | | | 25D. ADDRESS 7401 Belair Road | | | | | 25E. ADDRESS (36) | | | | |

CHURCH HOME & HOSPITAL
BALTIMORE, MD.

MD.
BALTIMORE
ET. 14 84 92

F W MARRIED 12-21-95 F

MARRIAGE

CHURCH HOME & HOSPITAL
BALTIMORE, MD.

12-12

12-17
12-18

12-19

12-19-97
CHURCH HOME & HOSPITAL
BALTIMORE, MD.

12-19-97
CHURCH HOME & HOSPITAL
BALTIMORE, MD.

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 13045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13045

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DEBORAH RANDALL

2. DATE AND HOUR PRONOUNCED DEAD

12-20-65

11:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL
DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

117 E. Clements Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Oct. 28, 1965

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

William E. Randall

14. MOTHER'S MAIDEN NAME

Joan E. Vinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

William E. Randall

ADDRESS

117 E. Clement St.

18. 492X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Acute interstitial pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-20-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12 21 1965

23C. NAME of CEMETERY or CREMATORY

Holy Cross

23D. LOCATION

(City, town, or county)

Brooklyn, A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave

WALTON TOWNSHIP

PAID COUNTY

Robert

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. | |
|--|--|--|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 65 13046 | | 65 13046 | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | WILLIAM FRANKLIN GARBER | | 2. DATE AND HOUR OF DEATH | | 12-19-65 6:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | A. STATE B. COUNTY | |
| CHURCH HOME + HOSPITAL | | | | BALTIMORE, MARYLAND | | Maryland USA | | | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| M | | | | W | | MARRIED | | 3-14-15 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| FORK OPERATOR | | | | FORK OPERATOR | | Penn. | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| HOBART GARBER | | | | AVADIA ULLOM | | | | 210-07-3493 | |
| 17. INFORMANT | | | | ADDRESS | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20411 | | | | CAUSE OF DEATH | | (A) Pneumonia, Bilateral | | | |
| | | | | | | (B) Myelomonocytic Leukemia | | | |
| | | | | | | (C) | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Pneumothorax + Atelectasis Rt Lung | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-16-65 to 12-19-65, that (I) (we) last saw the deceased alive on 12-16-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | | 12/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| WILLIAM A. TOLENTINO | | | | CHURCH HOME + HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Removal | | | | 12/21/65 | | Jefferson Memorial | | Jefferson, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 22 1965 | | | | R. L. A. J. J. J. | | Connellly Sons | | 300 Race Ave., Balt. | |

NOT A COPY OF

SEARCHED INDEXED
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FBI - BOSTON
JAN 10 1964

3-10-64

MAILED

W

M

FORK CREEK ROAD

ALABAMA

THREAT CARRIAGE

ALABAMA

FILED

1964

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 5-263 65 13047 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13047 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | SCHWIEGERATH, Michael | | 2. DATE AND HOUR OF DEATH 12/18/65 12:35 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | MARYLAND BALTIMORE | | | |
| BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | 5300 | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH 9/22/09 | | 9. AGE (In years lost birthday) 56 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME JACOB SCHWIEGERATH | | 14. MOTHER'S MAIDEN NAME ELIZABETH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218 01-0307 | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Avenue, Balto, Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) Pulmonary embolus (B) Thrombophlebitis (C) Coagulation of Aortic Graft | | INTERVAL BETWEEN ONSET AND DEATH Approx. 3 hrs. Unknown Approx. 24 hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/16/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Aneurysm | | 20A. AUTOPSY? (Yes, or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/17 1965 to 12/18 1965, that (I) (we) lost saw the deceased alive on 12/17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Stuart Weeks | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) R. Stuart Weeks | | 23D. ADDRESS M.D. BCH 4940 Eastern Ave., Balto, Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Balto. Md. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR W. E. Schmitt | |
| 25C. FUNERAL DIRECTOR Connolly Sons 3001 Race Ave., Balto. Md. | | ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13048 | |
|---|-----------|--|----------------------------|--|---|
| BIRTH NO. 65 13048 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Ringsborg LARS | | 2. DATE AND HOUR OF DEATH 12-19-65 4 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles Gen Hosp. | | A. STATE Maryland B. COUNTY BALTIMORE | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) White Marsh 5300 | | | |
| | | D. STREET ADDRESS (If rural, give location) Box 1044 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-11-1887 | 9. AGE (In years last birthday) 78 | (If Under 1 Yr. Months Days II Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor (Retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) DENMARK | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME UNKNOWN Christian Ringsborg | | 14. MOTHER'S MAIDEN NAME MARIA Gertrude Larson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-22-2350 | | 17. INFORMANT ADDRESS Chart | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 2 or 3 days. | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) PNEUMONIA DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ARTERIOSCLEROTIC DUE TO CARDIOVASCULAR DISEASE | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-16-65 1965 to 12-19 1965, that (I) (we) last saw the deceased alive on 12-19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Carlos E. Arana | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-19-1965 | |
| 23C. PHYSICIAN'S NAME (Type) FOR DR. J.R. BECK CARLOS E. ARANA | | M.D. | | 23D. ADDRESS 901 FUSELAGE AVE. 21220, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/65 | | 24C. NAME of CEMETERY or CREMATORY Garden of Faith | |
| 24D. LOCATION (City, town, or county) Balto. | | (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS 300 Ave | |

Continued (P. 2)

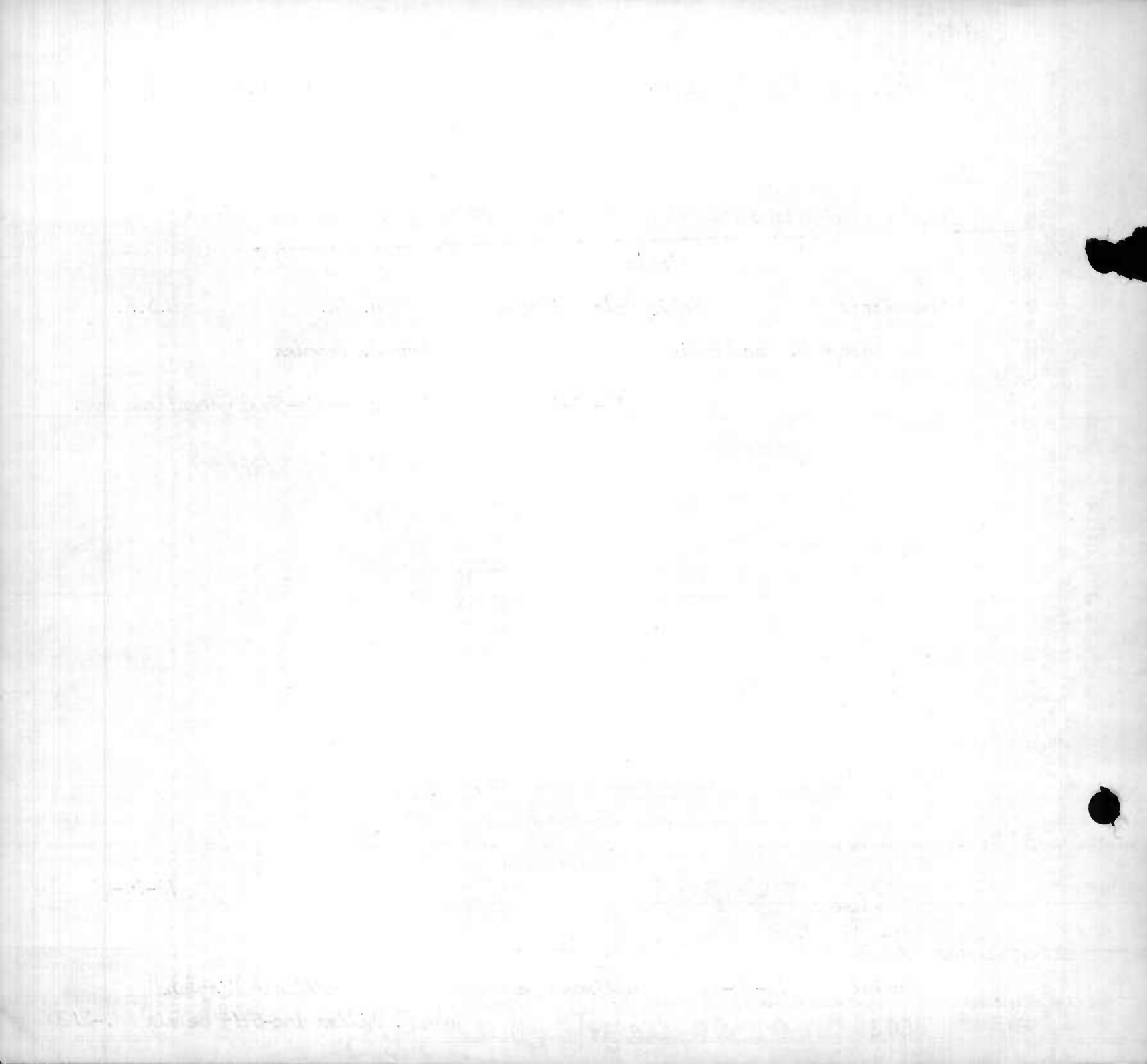
Continued (P. 2)

Continued (P. 2)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 13049 | |
|--|---------------------|--|---|---|---|
| BIRTH NO. | | | | 65 13049 | |
| M.E. CASE NO. | | | | 65 13049 | |
| 1. NAME OF DECEASED (Type or Print) <i>Alice Mackenzie</i> | | | 2. DATE AND HOUR OF DEATH <i>12-16-65 13:10 P.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>27-34</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hospital</i> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>5506 Greenfield Ave.</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>4-26-97</i> | 9. AGE (In years last birthday) <i>68</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Robin Dale Uniforms</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 13. FATHER'S NAME <i>Joseph W. Mac Kenzie</i> | | | 14. MOTHER'S MAIDEN NAME <i>Anna E. Peppler</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <i>214-01-1669</i> | | 17. INFORMANT <i>Louis Mac Kenzie-5506 Greenfield Ave.</i> |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>AS CVHD.</i> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) _____ | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-10-1965</i> to <i>12-16-1965</i> , that (I) (we) lost saw the deceased alive on <i>12-16-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>H. J. HARGRAVE</i> | | | | 23B. DATE SIGNED <i>12-16-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>H. J. HARGRAVE</i> | | | | 23D. ADDRESS <i>M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-20-65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Baltimore Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1965</i> | | 25B. NAME OF REGISTRAR <i>John C. Miller Inc-415 Belair Rd.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>John C. Miller Inc-415 Belair Rd.-21206</i> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13050

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL PARKER

2. DATE AND HOUR PRONOUNCED DEAD

12/18/65 12:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

135 N. Port St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

2/28/21

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Parker

14. MOTHER'S MAIDEN NAME

Mary Budacz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.

215-12-8389

17. INFORMANT

Joseph J. Parker Baltimore, Md.

ADDRESS

4 Everlasting La.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Massive subarachnoid hemorrhage originating
DUE TO from Circle of Willis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/22/65

23C. NAME of CEMETERY or CREMATORY

Meadowridge

23D. LOCATION

(City, town, or county)

(State)

Anne Arundle Co. Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

1217 St. Paul St.

Wm. Cook-Brooks Inc Baltimore, Md. 21202

VALLEY FORGE

THE AMERICAN CENTER FOR THE STUDY OF THE AMERICAN WEST
P.O. BOX 1000
DENVER, COLORADO 80202
TELEPHONE (303) 733-1000
FACSIMILE (303) 733-1001
CABLE (303) 733-1000
WWW.AMERICANWESTCENTER.ORG

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| BIRTH NO. | | 65 13052 | | | | Registered No. 65 13052 | | | |
| M.E. CASE NO. | | HENN, WILLIAM JOSEPH | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | | 12-17-65 4:22 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | A. STATE B. COUNTY | | | |
| ST AGNES HOSPITAL | | | | | | MARYLAND | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | | | GLEN BURNIE | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | | | 208 FERNDALERD. | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| MALE | | WHITE | | MARRIED | | 10-17-20 | | 45 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| NONEX Machinist | | Ret. | | MARYLAND | | U.S. | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | |
| WILLIAM Henn | | | | | | AGNES WEBER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes | | WW 11 | | 212-12-0049 | | CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) DUE TO Congestive heart failure | | | |
| | | | | | | (B) DUE TO Myocardial Infarction with chronic pericarditis | | | |
| | | | | | | (C) A. S. C. V. D. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-16-19 65 to 12-17-19 65, that (I) (we) last saw the deceased alive on 12-17-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | |
| RAPHAEL MARIN | | | | | | ST AGNES HOSPITAL, BALTO. 29, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 12/21/65 | | Baltimore National | | Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| DEC 22 1965 | | R. E. J. J. J. | | Kirkley Funeral Home (DH) | | | | | |

100:

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO: 65-312765 13053 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13053 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | ZELLERS, LEONARD III | | 2. DATE AND HOUR OF DEATH 12-18-65 3:40 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND SINAI HOSPITAL, BALTO 21215 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE AT GREENSPRING | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDAM LAKE 63200 | |
| 6. STREET ADDRESS (If rural, give location) 2019 EWALD AVE. #22 | | 7. SEX MALE | | 8. RACE CAUCASIAN | |
| 9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) SINGLE | | 10. DATE OF BIRTH 12-14-65 4 DAYS | | 11. AGE (In years last birthday) 4 | |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 13. KIND OF BUSINESS OR INDUSTRY NONE | | 14. BIRTHPLACE (State or foreign country) CHURCH HOME AND HOSPITAL BALTIMORE - MD | |
| 15. CITIZEN OF WHAT COUNTRY? USA | | 16. FATHER'S NAME LEONARD ZELLERS, JR | | 17. MOTHER'S MAIDEN NAME SANDRA KLIMOVITZ | |
| 18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE | | 19. SOCIAL SECURITY NO. NONE | | 20. INFORMANT FATHER - LEONARD JR. ADDRESS 2019 EWALD AVE #22 BALTO - MD | |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 22. CAUSE OF DEATH (A) RESPIRATORY DUE TO INSUFFICIENCY (B) TOXEMIA DUE TO DUE TO INFECTION (C) | | 23. INTERVAL BETWEEN ONSET AND DEATH | |
| 24. DATE OF OPERATION 12-17-65 | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 26. AUTOPSY? (Yes or No) — | |
| 27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 28. DATE OF OPERATION 12-17-65 | | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 30. DATE OF OPERATION 12-17-65 | | 31. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 32. AUTOPSY? (Yes or No) — | |
| 33. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 34. DATE OF OPERATION 12-17-65 | | 35. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 36. AUTOPSY? (Yes or No) — | | 37. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 38. DATE OF OPERATION 12-17-65 | |
| 39. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 40. DATE OF OPERATION 12-17-65 | | 41. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 42. AUTOPSY? (Yes or No) — | | 43. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 44. DATE OF OPERATION 12-17-65 | |
| 45. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 46. DATE OF OPERATION 12-17-65 | | 47. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 48. AUTOPSY? (Yes or No) — | | 49. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 50. DATE OF OPERATION 12-17-65 | |
| 51. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 52. DATE OF OPERATION 12-17-65 | | 53. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 54. AUTOPSY? (Yes or No) — | | 55. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 56. DATE OF OPERATION 12-17-65 | |
| 57. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 58. DATE OF OPERATION 12-17-65 | | 59. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 60. AUTOPSY? (Yes or No) — | | 61. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 62. DATE OF OPERATION 12-17-65 | |
| 63. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 64. DATE OF OPERATION 12-17-65 | | 65. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 66. AUTOPSY? (Yes or No) — | | 67. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 68. DATE OF OPERATION 12-17-65 | |
| 69. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 70. DATE OF OPERATION 12-17-65 | | 71. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 72. AUTOPSY? (Yes or No) — | | 73. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 74. DATE OF OPERATION 12-17-65 | |
| 75. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 76. DATE OF OPERATION 12-17-65 | | 77. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 78. AUTOPSY? (Yes or No) — | | 79. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 80. DATE OF OPERATION 12-17-65 | |
| 81. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 82. DATE OF OPERATION 12-17-65 | | 83. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 84. AUTOPSY? (Yes or No) — | | 85. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 86. DATE OF OPERATION 12-17-65 | |
| 87. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | | 88. DATE OF OPERATION 12-17-65 | | 89. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED MENINGO MYELOIDITIS | |
| 90. AUTOPSY? (Yes or No) — | | 91. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 92. DATE OF OPERATION 12-17-65 | |
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| 372. AUTOPSY? (Yes | | | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|--|--------------------------------------|--|--|
| BIRTH NO. 65 13054 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13054 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LOUIS SCHMITT | | 2. DATE AND HOUR OF DEATH Dec. 19, 1965 5:30 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND BALTIMORE CITY HOSPITALS FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5907 Belair Road 21206 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9-15-1868 | 9. AGE (In years lost birthday) 97 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY COOK | | 11. BIRTHPLACE (State or foreign country) FRANCE | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME CHRISTIAN SCHMITT | | | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Generalized Arteriosclerosis DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH Years | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC. 25 19 64 to DEC. 19 19 65 , that (I) (we) last saw the deceased alive on DEC. 19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Barry Wayne UHR | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec. 19, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) BARRY WAYNE UHR | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland BALTIMORE CITY HOSPITALS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-23-65 | | 24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM | |
| 24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD. BALTO., MD. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | | | |
| 25B. NAME OF REGISTRAR Charles E. Zeiler | | 25C. FUNERAL DIRECTOR ADDRESS 6224 EASTERN AVE. BALTO., MD. | | | |

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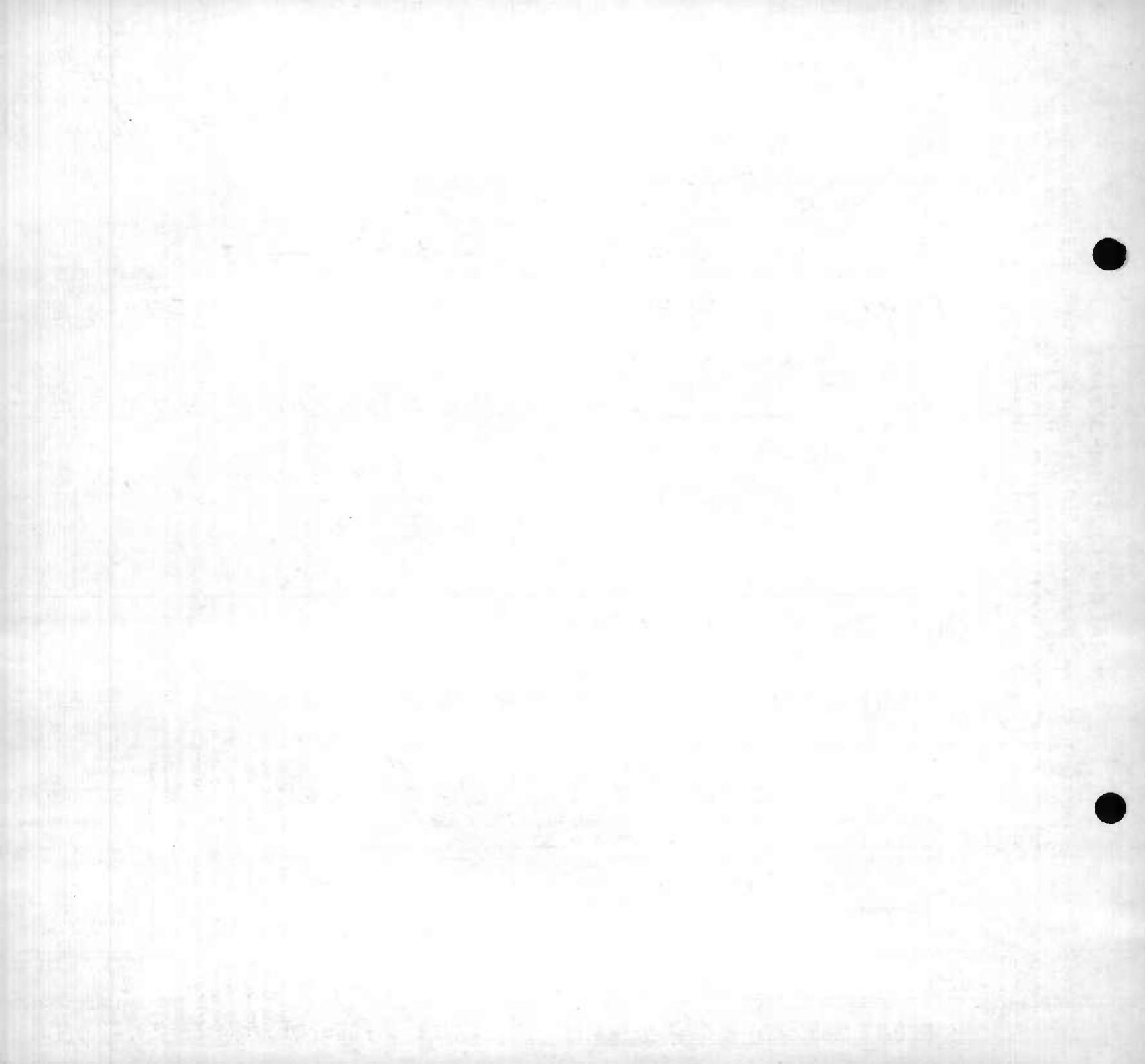
UNRECORDED

CHARTERED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

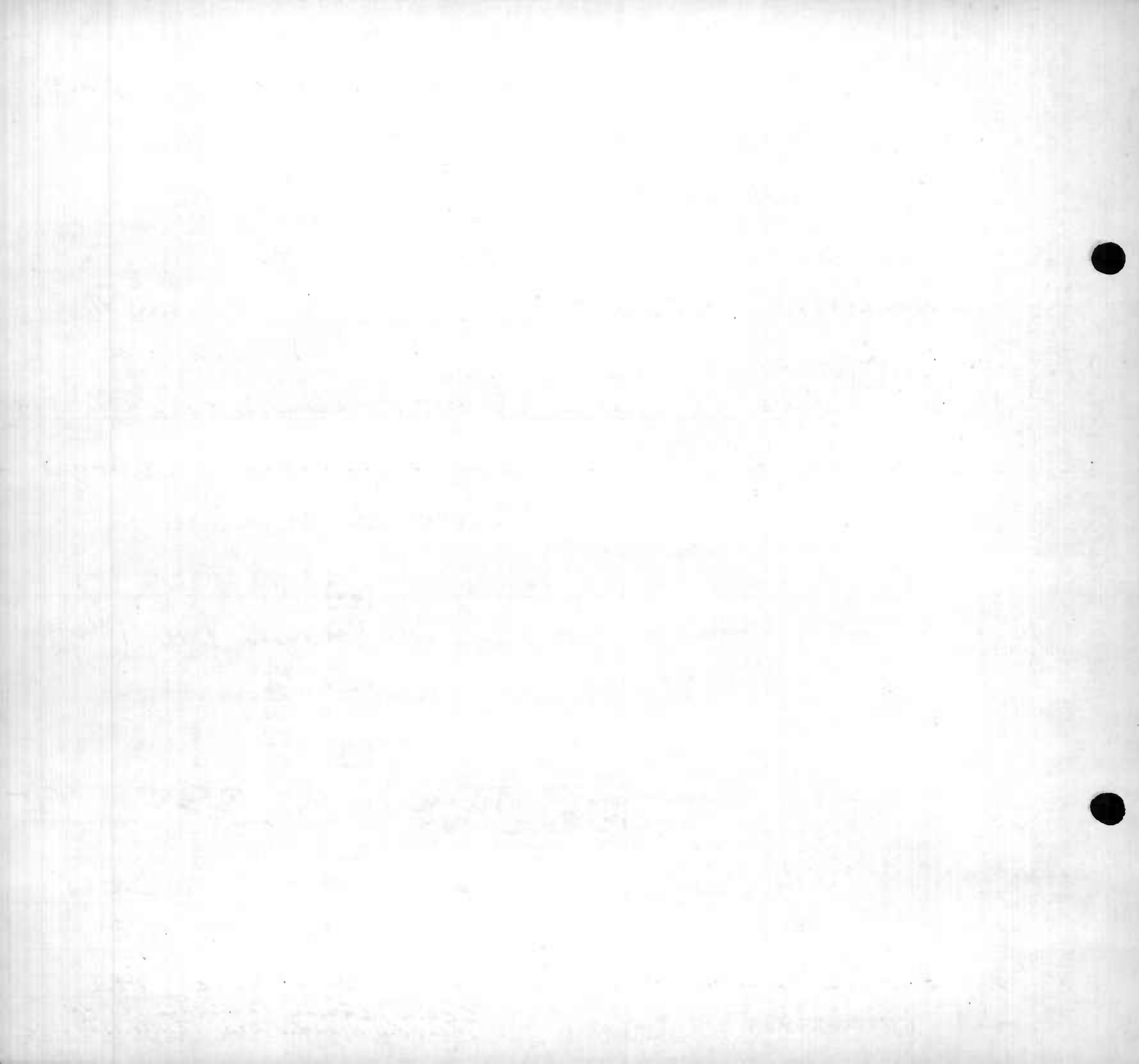
| BIRTH NO. | | 65 13055 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 13055 | |
|---|---------------------|--|---|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) RAFFAELE RALPH FANTACONE | | | | 2. DATE AND HOUR OF DEATH DEC. 17, 1965 11:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE, MARYLAND-21207 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY 1417 W. Pratt St. (Maryland) C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23 D. STREET ADDRESS (If rural, give location) (above) 1903 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 12/15/27 | 9. AGE (In years last birthday) 38 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor | | |
| 11. BIRTHPLACE (State or foreign country) ITALY | | | 12. CITIZEN OF WHAT COUNTRY? ITALY | | | 13. FATHER'S NAME Fantacone | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 217-18-6269 | |
| 17. INFORMANT Mary Prather (daughter) | | | ADDRESS 1417 W. Pratt St. | | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLUS, SUSPECTED ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. THROMBOPHLEBITIS | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 11/18 1965 to 12/17 1965 , that (I) (we) last saw the deceased alive on 12/17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Martin C. Shargel M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23B. DATE SIGNED 12/17/65 | | 23C. PHYSICIAN'S NAME (Type) MARTIN C. SHARGEL | | 23D. ADDRESS UNIVERSITY HOSPITAL, BALTO., MD | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | |
| 25B. NAME OF REGISTRAR Walters Funeral Home - Balto., Md. | | 25C. FUNERAL DIRECTOR ADDRESS | | 25D. DATE OF DEATH DEC 17 1965 | | 25E. TIME OF DEATH 11:45 A.M. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 13056 | |
|---|----------------------|--|--------------------------------------|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 65 13056 | | 1. NAME OF DECEASED (Type or Print) ROBERT REGESTER COLLINS SR. | | 2. DATE AND HOUR OF DEATH DECEMBER 19, 1965 7:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland. B. COUNTY 19-04 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1623 McHenry St. | | D. STREET ADDRESS (If rural, give location) 1623 McHenry St. | | E. AGE (In years last birthday) 84 | |
| 5. SEX MALE | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH JUNE 1, 1881 | 9. AGE (In years last birthday) 84 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST | | 10B. KIND OF BUSINESS OR INDUSTRY TRANSIT CO. | | 11. BIRTHPLACE (State or foreign country) MARYLAND. | |
| 13. FATHER'S NAME Joseph COLLINS | | 14. MOTHER'S MAIDEN NAME MARY E. Robinson | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | |
| 16. SOCIAL SECURITY NO. 213-05-9919 | | 17. INFORMANT Robt. R. COLLINS, Jr. | | ADDRESS 730 S. Woodington Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia | | CAUSE OF DEATH (A) DUE TO Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH 10 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Arteriosclerotic CV Disease | | (B) DUE TO Arteriosclerotic CV Disease | | (C) _____ | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Aquamous Cell Carcinoma, face 1 1/2 yrs | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1964 to Dec 1965 that (I) (we) last saw the deceased alive on 13 Dec 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. H. Bayliss | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 20 Dec 65 | |
| 23C. PHYSICIAN'S NAME (Type) H. H. BAYLISS | | 23D. ADDRESS 1600 WILKENS AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-23-65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL | |
| 24D. LOCATION (City, town, or county) BALTIMORE | | (State) Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 22 1965 | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR GEO. L. Schwab FUNERAL HOME | | | |
| ADDRESS 2101 FREDERICK AVE. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13057 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13057 | |
|---|----------------------|---|---|---|---|--|--|
| M.E. CASE NO. 65 13057 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Ralph C Gerdon</u> | | | | 2. DATE AND HOUR OF DEATH <u>17 Dec 65</u> <u>1 8 20</u> A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Maryland General Hosp</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 Linden Ave</u> <u>Baltimore 1, Md.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Hartford</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Aberdeen, Md</u> D. STREET ADDRESS (If rural, give location) <u>33 Rigdon Road</u> | | | |
| 5. SEX <u>M.</u> | 6. RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Aug 21, 1896</u> | 9. AGE (In years lost birthday) <u>69</u> | 10. If Under 1 Yr. Months Days | 11. If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ordnance engineer</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Sandy Hook, N. J.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Clarence G. Gerdon</u> | | | 14. MOTHER'S MAIDEN NAME <u>Grace Jewell</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>U.S. Army WWI</u> | | | 16. SOCIAL SECURITY NO. ? <u>None</u> | | 17. INFORMANT <u>wife</u> | | ADDRESS <u>33 Rigdon Rd Aberdeen Maryland</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>457X I</u> | | | CAUSE OF DEATH (A) <u>Massive retroperitoneal hemorrhage</u> (B) <u>Ruptured abd. aneurysm</u> (C) <u>Arteriosclerotic G.V. disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Prior hx of myocardial infarct</u> | | | | |
| 19A. DATE OF OPERATION <u>17 Dec 65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ruptured aneurysm</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u> | | 21C. WHERE DID INJURY OCCUR? <u></u> | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) <u></u> | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u></u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>17 Dec 65</u> 19 to <u>17 Dec 65</u> 19, that (I) (we) last saw the deceased alive on <u>17 Dec 65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Thomas Crawford</u> | | | | | | 23B. DATE SIGNED <u>17 Dec 65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Thomas Crawford</u> | | | | | | 23D. ADDRESS <u>M.D. 111 W. Monument St. Balto 1.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/20/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Grove Presbyterian Cemetery, Aberdeen, Md.</u> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Wesley W. Gough</u> | | 25D. ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u> | |

The following is a list of the
 names of the persons who
 were present at the
 meeting of the
 Board of Directors
 held on the 1st day of
 January, 1900.

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 names of the persons who
 were present at the
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 were present at the
 meeting of the
 Board of Directors
 held on the 1st day of
 January, 1900.

65 13058

BALTIMORE CITY HEALTH DEPARTMENT

65 13058

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VINCENT

SANSOSTI

2. DATE AND HOUR PRONOUNCED DEAD

12/19/65 10:30 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3328 Paine St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3328 Paine St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

July 23, 1953

9. AGE (In years
last birthday)

12

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Vincent J. Sansosti

14. MOTHER'S MAIDEN NAME

Dorothy Edna Duvall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. (If yes, give war or dates of service))

no

16. SOCIAL
SECURITY NO.
none

17. INFORMANT

ADDRESS

Mr. Vincent J. Sansosti 3328 Paine Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Inter-atrial septal defect
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

22 Dec. 65

23C. NAME OF CEMETERY or CREMATORY

Druid Ridge Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore County Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 23 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Burgee Funeral Home 3631 Falls Road

VALLEY FORGE

5500 LOCUST

1-2-A

8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13059 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13059 | |
|---|---------------------|--|--|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) ROSA B. PUTNAM | | | | 2. DATE AND HOUR OF DEATH Dec. 19, 1965 7:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE-MARYLAND B. COUNTY 9-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3917 EDNOR ROAD 21218 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3917 EDNOR ROAD-21218 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 2-18-1867 | 9. AGE (In years lost birthday) 98 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER | | | 10B. KIND OF BUSINESS OR INDUSTRY COLUMBIA HOSPITAL WASH. D.C. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE-MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME ROBERT B. MEADS | | | 14. MOTHER'S MAIDEN NAME MARY ELIZABETH (LAST NAME UNKNOWN) | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ROBERT M. PUTNAM - 3917 EDNOR RD. BALTIMORE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute pulmonary edema Sudden | | | CAUSE OF DEATH (A) DUE TO Chronic myocarditis | | INTERVAL BETWEEN ONSET AND DEATH Atypical pneumonia (Nov 15, 1965) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Senility | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 16, 1959 to Dec. 19, 1965 , that (I) (we) last saw the deceased alive on Dec. 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H.V. Harbold M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec. 19, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) H.V. HARBOLD M.D. | | | | 23D. ADDRESS 4706 HARTFORD ROAD BALTIMORE-14, MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-21-65 | | 24C. NAME OF CEMETERY or CREMATORY CEDAR HILL CEMETERY | | 24D. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Washington ADDRESS 2400 N. DeVol, 2224 W. Ave. N.W. | | | |

BURIAL 12-21-66 CEDAR HILL CEMETERY, EAST AND MARY-
ST. ANNE PARK 2222 N. 10th St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LILLIAN

MAE
TALIAFERROBALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65 13060

2. DATE AND HOUR OF DEATH

12.17.65

4:55P

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)THE JOHNS HOPKINS HOSPITAL
601 N. BROADWAY
BALTIMORE, MD 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

HARFORD

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BRADSHAW

Joppa,

21021

21085

D. STREET ADDRESS

(If rural, give location)

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10-4-06

9. AGE (In years
lost birthday)

59

10. Under 1 Yr.

Months Days Hours Min.

11. Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Presser

10B. KIND OF BUSINESS OR INDUSTRY

Laundry

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.,

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

KUPER, FREDDIE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

215-14-0985

17. INFORMANT

ADDRESS

Morris Taliaferro Bradshaw

Maryland.

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10.13 19 65 to 12.17 19 65
that (I) (we) last saw the deceased alive on 12.17. 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Herman K. Gold

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

12.17.65

23C. PHYSICIAN'S
NAME (Type)

Herman K. Gold

M.D.

23D. ADDRESS

Johns Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

Dec. 20, 1965 Garden Of Eternal Hope

Gamber, Carroll, Maryland.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 23 1965

Howard K. McComas & Son Abingdon Maryland.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--|---|--|--|--|
| 65 13061 | | CERTIFICATE OF DEATH | | 65 13061 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | Catherine M. Spates | | DEC. 19, 1965 8:30 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | MD. | | 12-01 | |
| UNION MEMORIAL HOSP. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| D. STREET ADDRESS (If rural, give location) | | BROADVIEW APTS-39th & UNIV. PKW. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years at birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| WHITE | WHITE | WIDOWED | JAN 15, 1884 | 81 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| HOUSEWIFE | HOME | MARYLAND | U.S. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| CHARLES WAGNER | | MARY ANN McGRATH | | No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| UNK. | | MR. William H. Spates, Jr. | | SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Myocardial infarction | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Ane | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | YES | YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from DEC. 5 19 65 to DEC. 19 19 65, that (we) last saw the deceased alive on DEC. 19 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | M.D. | Attending Phys. <input type="checkbox"/> | Med. Director <input type="checkbox"/> | Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED |
| L. Evan Custer | | | | | DEC. 19, 1965 |
| 23C. PHYSICIAN'S NAME (Type) | 23D. ADDRESS | | | | |
| L. EVAN CUSTER, | UNION MEMORIAL HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| BURIAL | 12/22/65 | CATHEDRAL CEMETERY | BALTIMORE, MD. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 23 1965 | Robert E. Spates | H. W. MEARS & SON | | 805 N. CALVERT S | |

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a list or table. Some legible fragments include:

- Top left: "The first..."
- Top right: "The second..."
- Middle left: "The third..."
- Middle right: "The fourth..."
- Bottom left: "The fifth..."
- Bottom right: "The sixth..."

The document is heavily faded and shows significant signs of age and wear, including two dark circular marks on the right edge.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|--|---|---|
| BIRTH NO. 65 13062 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13062 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| REVEREND JOHN SINNOTT MARTIN | | | DECEMBER 19, 1965 9:50 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. #29 | | | A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #21202 D. STREET ADDRESS (If rural, give location) 120 N. FRONT STREET | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 10-13-94 | 9. AGE (In years lost birthday) 71 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS (CATHOLIC PRIEST) | | 10B. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FREDERICK T. MARTIN | | | 14. MOTHER'S MAIDEN NAME MARY SINNOTT | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS BALTO., #29 ST. AGNES RECORDS-WILKENS & CATON AVES. | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Cardiac Arrest</i> DUE TO (B) <i>Myocardial Infarction</i> DUE TO (C) <i>ASCD</i> | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 1</u> 19 <u>65</u> to <u>DECEMBER 19</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>DECEMBER 19</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> M.D. | | | | 23B. DATE SIGNED <u>12-19-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) MIGUEL HEREDIA | | | | 23D. ADDRESS WILKENS & CATON AVES. BALTO. #29 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/22/65 | | 24C. NAME OF CEMETERY or CREMATORY CATHEDRAL CEMETERY | |
| 24D. LOCATION BALTIMORE, MD. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | | |
| 25B. NAME OF REGISTRAR <i>[Signature]</i> | | 25C. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST | | | |

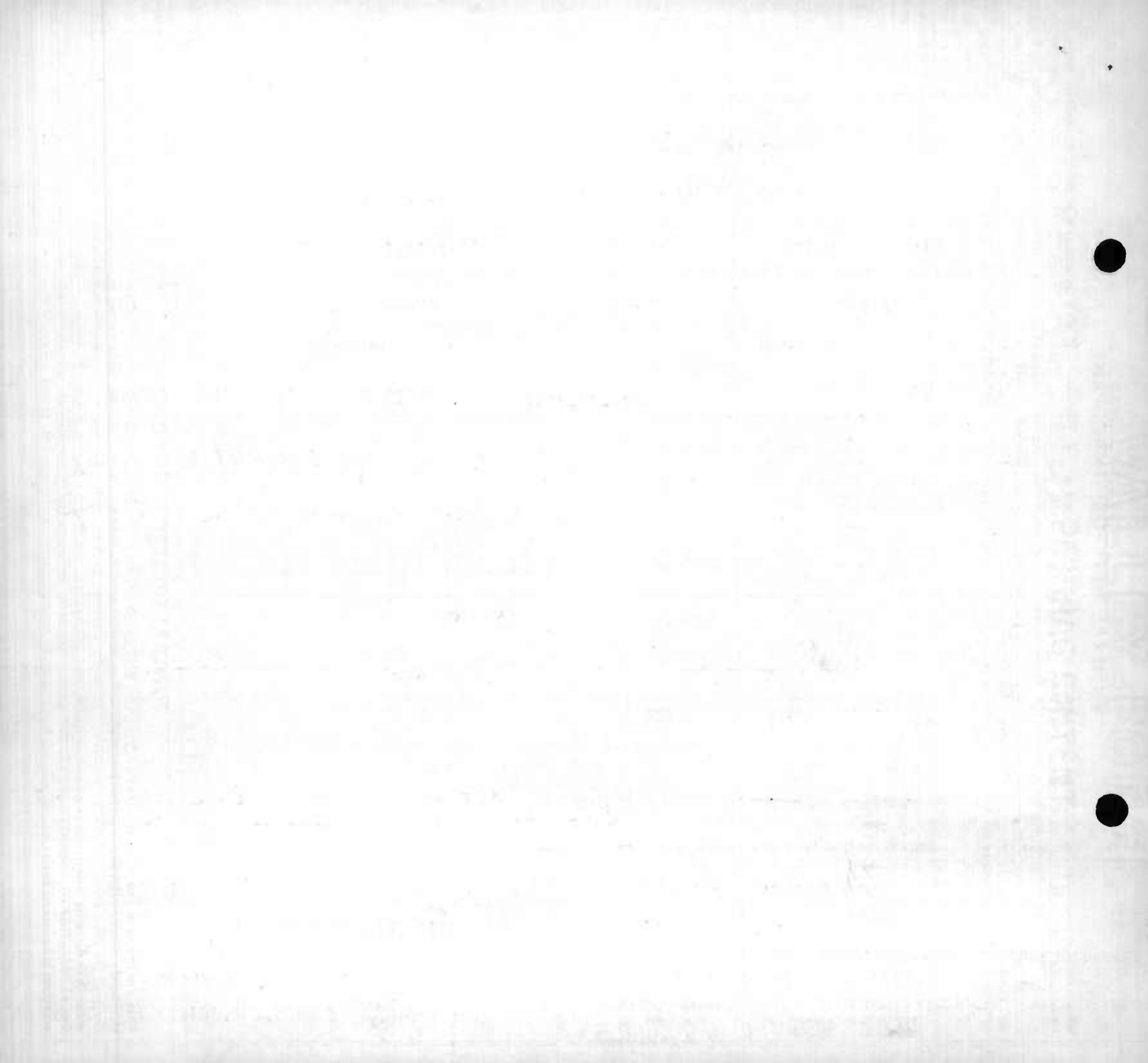
Wm. L. Garrison
New York

[Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

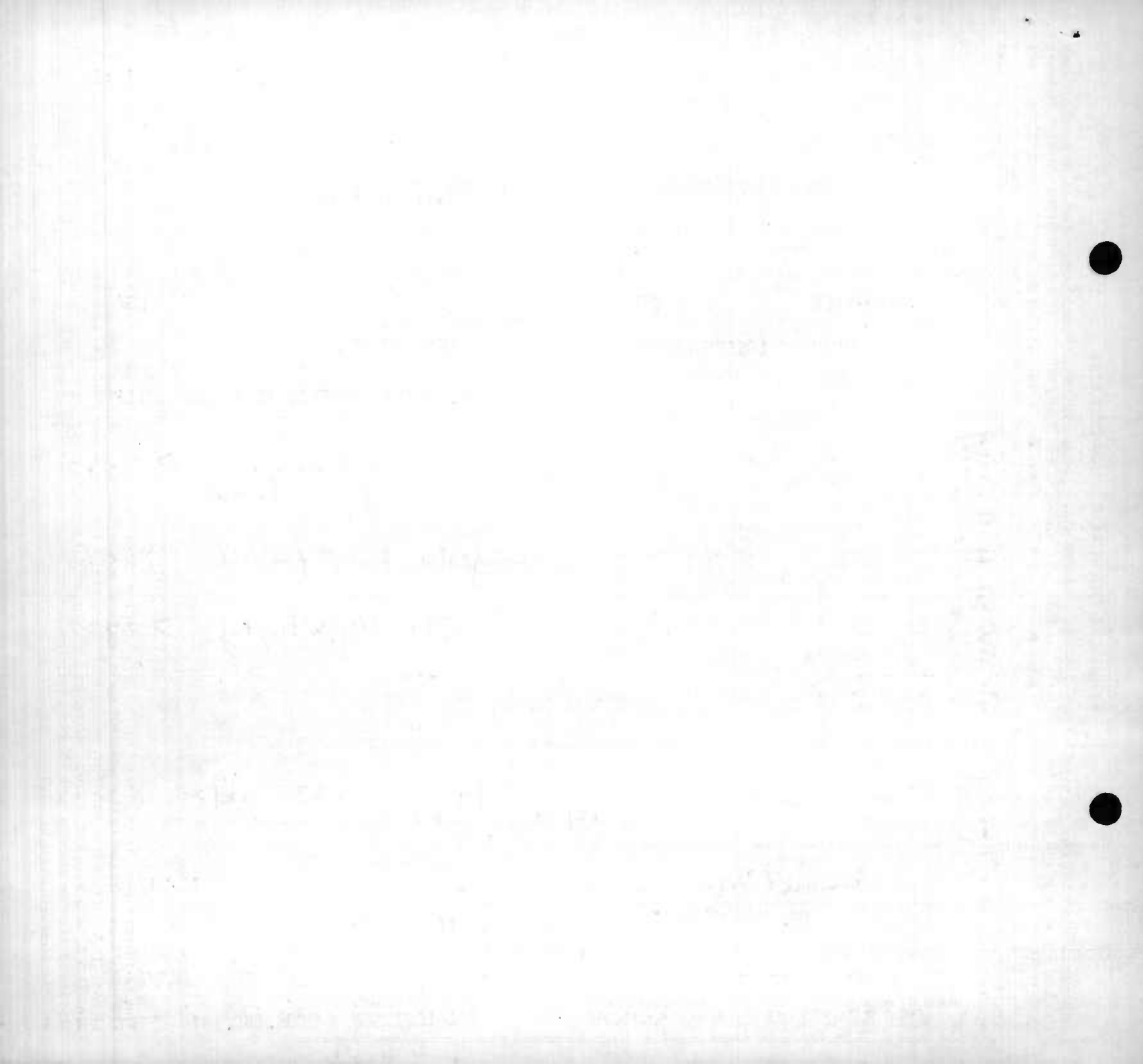
| BIRTH NO. 65 13063 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13063 | |
|---|---------|--|------------------|---|-----------------------|--|-----------------------|
| M.E. CASE NO. | | | | 20 | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| DAVID GOLDSTEIN | | | | DECEMBER 21, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 48 MARYLAND GENERAL HOSPITAL | | | | MARYLAND | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 4721 BEAUFORT AVENUE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Min. |
| MALE | WHITE | MARRIED | 12/7/1891 | 74 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| TAILOR | | RETIRED | | TURKEY | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| UNKNOWN | | | | UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | 216-10-1538 | | MRS. DORIS LISSY 4907 NELSON AVENUE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | 1 day | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | 7 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II | | | | none | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | no | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> At Home <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6:30 to 1965 to Dec 21 1965, that (I) last saw the deceased alive on Dec 21 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Manuel Levin | | | | 12/22/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| DR. MANUEL LEVIN | | | | 4818 REISTERSTOWN ROAD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 12/22/65 | | HEBREW YOUNG MEN | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR & ADDRESS | | | |
| DEC 23 1965 | | Sol Levinson | | SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

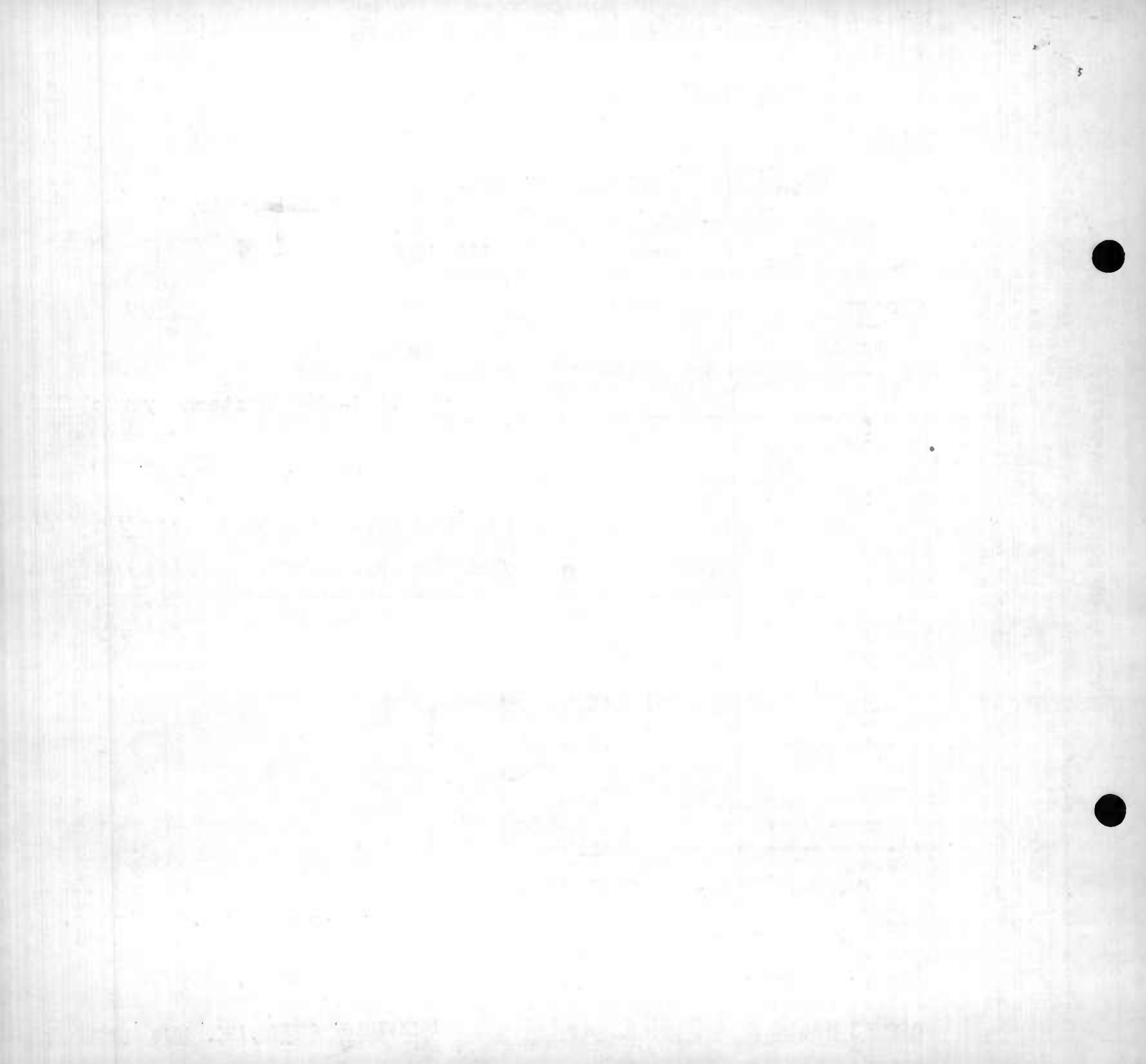
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------|--|---|
| BIRTH NO. 65 13061 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13064 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MORRIS SCHLOSSBERG | | 2. DATE AND HOUR OF DEATH DECEMBER 20, 1965 10:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4906 ELMER AVENUE | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-18 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4906 ELMER AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER | | 10B. KIND OF BUSINESS OR INDUSTRY TAVERN | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME HYMAN SCHLOSSENBERG | | 14. MOTHER'S MAIDEN NAME LEAH SOBEL | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. SYLVIA EPSTEIN 6251 ROBIN HILL RD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Emphysema | | CAUSE OF DEATH (A) DUE TO Benign | | INTERVAL BETWEEN ONSET AND DEATH > 3 yrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive heart failure | | (B) DUE TO 8 weeks | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prostatic Hypertrophy | | | | > 3 yrs | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/4 1963 to 12/20 1965 , that (I) (we) last saw the deceased alive on 12/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Samuel Morrison | | | | 23B. DATE SIGNED 12/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. SAM MORRISON | | 23D. ADDRESS 11 EAST CHASE STREET | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON) | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR DR. J. E. JONES | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

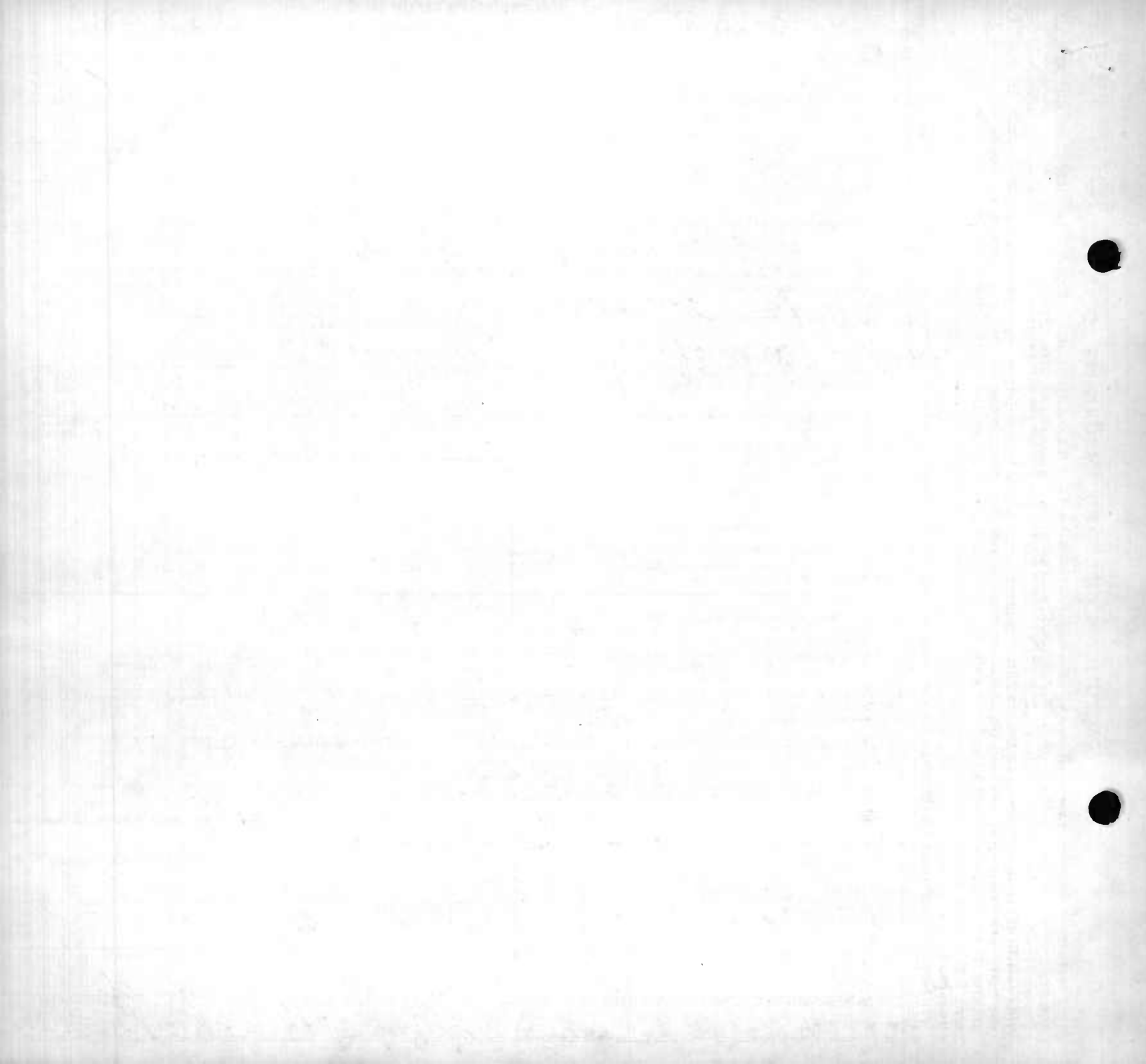
| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. <u>7-360</u> <u>65 13065</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 13065</u> | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>Samuel Tattar</u> | | | 12-20-65 3:15 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | Maryland 86-09 | | |
| 5. SEX Male | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| 6. RACE White | | | Baltimore | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | | D. STREET ADDRESS (If rural, give location) | | |
| 8. DATE OF BIRTH 10/2/1888 | | | 838 South Conkling Street | | |
| 9. AGE (In years last birthday) 77 | | | 11. BIRTHPLACE (State or foreign country) | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u> | | | RUSSIA | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | | ADDRESS | | |
| Records: BCH-4940 Eastern Avenue 21224 | | | | | |
| 18. <u>610X</u> I | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) <u>Uremia + Anemia</u> 1 month | | |
| ANTECEDENT CAUSES | | | (B) <u>Obstructive Uropathy</u> indefinite - 71 years | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) <u>Prostatic hypertrophy</u> indefinite | | |
| II | | | Cerebral insufficiency | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Cerebral Arterial insufficiency 20-5 years | | |
| 19A. DATE OF OPERATION <u>None</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <u>No</u> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED | | | 21F. HOW DID INJURY OCCUR? | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-14-</u> 19 <u>65</u> to <u>11-20</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-20</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert R. Kent</u> | | | 23B. DATE SIGNED <u>12-20-65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert R. Kent</u> | | | 23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Baltimore City Hospital, Maryland</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12/21/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>BNAI ISRAEL</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>R. R. Kent</u> | | 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 13066 | |
|--|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 21 65 13066 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Rovers, Dana | | 2. DATE AND HOUR OF DEATH 12/21/65 1:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE MD B. COUNTY 28-31 | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Sinai Hospital | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) 4800 Reisterstown Rd | | | |
| 5. SEX FEMALE | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED Widowed | 8. DATE OF BIRTH 3/25/93 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Jacob Yarmofsky | | 14. MOTHER'S MAIDEN NAME Moore? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Norma Roman ADDRESS 5919 Ave Lemmora | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ISCVD | | CAUSE OF DEATH (A) ISCVD (B) ASCVD (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Renal Failure Anemia (unknown etiology) | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/19 19 65 to 12/21 19 65 , that (I) (we) last saw the deceased alive on 12/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Leonard J. Hertzberg | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) Leonard J. Hertzberg | | 23D. ADDRESS St. Sinai Hosp. | | | |
| 24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial Dec 23/65 | | 24C. NAME OF CEMETERY or CREMATORY Moses Montefiore | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR Sal Leung | | 25C. FUNERAL DIRECTOR Sal Leung ADDRESS 2100 Reisterstown Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13067 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13067 | |
|---|-------------------------|--|---|--|--|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Lillian B. Mills</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/21/65 12N.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i> | | | | A. STATE <i>Maryland.</i> B. COUNTY <i>15-06</i> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 17</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>3015 Clifton Ave.</i> | | | |
| 5. SEX <i>Fem.</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>8/18/09</i> | | 9. AGE (In years last birthday) <i>56</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Rockville, S. C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> |
| 13. FATHER'S NAME <i>Charles Brown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Daisy Jenkins</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>217-22-7831</i> | | 17. INFORMANT ADDRESS <i>Hilda Hawley - 3015 Clifton Ave.</i> | | |
| 18. <i>157X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the pancreas</i> ANTECEDENT CAUSES <i>METASTATIC CA TO THE LUNGS</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) <i>Carcinoma of the pancreas</i> DUE TO (B) <i>METASTATIC CA TO THE LUNGS</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>?</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/12</i> 19 <i>65</i> to <i>12/21</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/21</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Florabian S. Peroma</i> M.D. | | | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. <i>LUTHERAN HOSPITAL OF MARYLAND</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-24-65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Arbutus Memorial Park</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 23 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Charles R. Law 802 Madison Ave.</i> | | | |

Section 2, 11, 12

Between Hospital

For: —

3012 Clifton Ave
Baltimore, Md
Maryland
8/18/09 26

Government of the Republic
Historical Co. to the Library

18/01

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12/21

Historical & Genealogical

Library, National Archives & Records Administration

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--------------------|--|--|--|--|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13068 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | PERRY D. G. PENNINGTON | | 2. DATE AND HOUR OF DEATH 12-22-65 11205 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1518 McCulloh Street | | A. STATE Maryland | | | |
| (If not in hospital or institution, give street address or location) | | B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1518 McCulloh Street | | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 4, 1884 | 9. AGE (In years last birthday) 81 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (Retired) |
| | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Perry Pennington | | | 14. MOTHER'S MAIDEN NAME Amanda Smith | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Pearl Pennington - 1518 McCulloh St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 600.0 I | | CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) Hypertension DUE TO (C) Chronic Pyelonephritis | | INTERVAL BETWEEN ONSET AND DEATH 3 hours ? ? | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-27 1960 to 12-22 1965, that (I) (we) last saw the deceased alive on 12-21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. K. Adams | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-22-65 | |
| 23C. PHYSICIAN'S NAME (Type) F. K. ADAMS | | 23D. ADDRESS M.D. 1222 N. Caroline St. Baltimore Md 21213 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY or CREMATORY Lincoln Memorial | |
| | | | | 24D. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR R. B. E. Indiana | | 25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13069 | |
|--|------------------|--|------------------------------|---|--|
| BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) | | 65 13069 Sallie Michens | | 2. DATE AND HOUR OF DEATH 12-21-65 4:5 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | 2231 Penrose Street AVE 21223 | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-8-1896 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Hannibal Brockington | | 14. MOTHER'S MAIDEN NAME Nellie Hamilton | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) DUE TO RHD C AS, AI, MS + CHF INTERVAL BETWEEN ONSET AND DEATH 8+ years | | CAUSE OF DEATH DUE TO (B) DUE TO (C) DUE TO | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 10-29-1965 to 12-21-1965 that (I) (we) last saw the deceased alive on 12-21-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Alan E. Oestrich M.D. | | 23B. DATE SIGNED 12-21-65 | | 23C. PHYSICIAN'S NAME (Type) Dr. Alan E. Oestrich M.D. | |
| 23D. ADDRESS 4940 Eastern Avenue Balto., Md. 21224 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-27-65 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Charles R. Law | |
| ADDRESS 802 Madison Ave. | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------|--|---|--|--|
| BIRTH NO. 65 13070 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13070 | |
| 1. NAME OF DECEASED (Type or Print) Mileva Yovanovich | | | 2. DATE AND HOUR OF DEATH 12/18/65 6 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland B. COUNTY 19-03 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | D. STREET ADDRESS (If rural, give location) | | |
| Baltimore | | | 1300 McHenry St. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 7/12/78 | 9. AGE (In years last birthday) 87 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Yugoslavia | | 12. CITIZEN OF WHAT COUNTRY? Yugoslavia |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Stevan Vukcevic 1300 McHenry St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 332X I Thrombosis Cerebral | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from Oct 1 19 65 to Dec 18 19 65, that (I) (we) last saw the deceased alive on 12-18- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE C. F. Mendelis M.D. | | | | 23B. DATE SIGNED 12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) C. F. Mendelis M.D. | | | | 23D. ADDRESS 2308 Edmondson Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR R. E. Fendley M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Worthy Funeral Home Pruthi Street | |

Thompson's Circular

Oct 15-18-1912

Dec 18-1912

Get Members
x

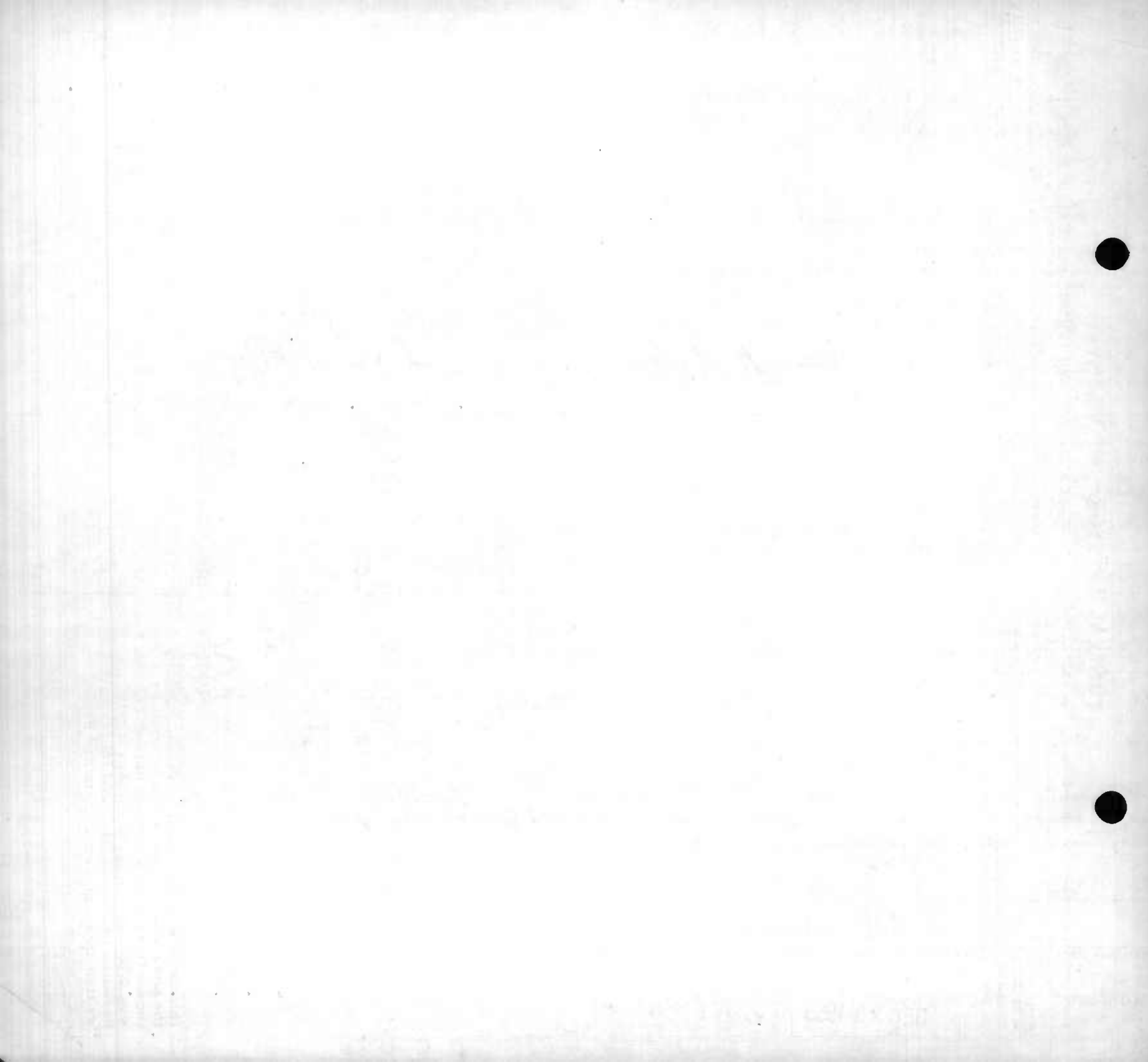
2308 24th Avenue

12/10/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13071 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13071 | |
|--|------------|--|-------------------------|---|-----------------------------|---|------------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) John H. Hyson | | | |
| 2. DATE AND HOUR OF DEATH 12-21-65 4: A. M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY Maryland 2403 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | Baltimore #21230 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | South Baltimore General Hosp 1204 Riverside Ave. | | | |
| 5. SEX M. | 6. RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M. | 8. DATE OF BIRTH 8-5-01 | 9. AGE (In years last birthday) 64. | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker | | 10B. KIND OF BUSINESS OR INDUSTRY Bakery | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Charles H. Hyson | | | | 14. MOTHER'S MAIDEN NAME Ida Kelly | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Bertha M. Hyson | |
| | | | | ADDRESS 1204 Riverside av | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) MYOCARDIAL INFARCTION DUE TO | | | |
| | | | | (B) ARTERIOSCLEROTIC CORONARY ARTERY DISEASE DUE TO | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | PERFORATED GASTRIC ULCER | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that the (this hospital) attended the deceased from 12-11 19 65 to 12-21 19 65, that we last saw the deceased alive on 12-21 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE James F. McCarter M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-21-65. | | | |
| 23C. PHYSICIAN'S NAME (Type) JAMES FRANKLIN MCCARTER M.D. | | | | 23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12 24 65 | | 24C. NAME of CEMETERY or CREMATORY Cedar Hill | | 24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT DEC 23 1965 | | 25B. NAME OF REGISTRAR Robert E. J. J. | | 25C. FUNERAL DIRECTOR Mc Cully | | ADDRESS 130 E. Fort Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|--|--|--|---|
| BIRTH NO. 65 13072 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John C. Zileh | | 2. DATE AND HOUR OF DEATH 21 Dec 65 1200 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Fayette Nursing Home | | A. STATE Md. B. COUNTY 2402 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 414 E Cross St 21230 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) S. | 8. DATE OF BIRTH 11/1/1899 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Gen. Bldg. | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Lo La W. | | 14. MOTHER'S MAIDEN NAME K. M. J. J. J. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Huber mccc 414 E Cross St 21230 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Branchiopneumonia | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 11d | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Chronic Bronchitis | | — | |
| (C) DUE TO | | | | — | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCD, Parkinson's, Rt Hydrocele | | | | — | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 31 Jul 1965 to 21 Dec 1965 , that (I) (we) last saw the deceased alive on 21 Dec 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Hulla | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 21 Dec 65 | |
| 23C. PHYSICIAN'S NAME (Type) J. Hulla | | 23D. ADDRESS M.D. 2214 E Fayette St. 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 12/24/65 | 24C. NAME OF CEMETERY OR CREMATORY Baeto. | | 24D. LOCATION (City, town, or county) (State) Baeto Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR J. C. J. | | 25C. FUNERAL DIRECTOR K. C. J. | |
| | | | | ADDRESS 130 E Tow. A. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|------------------|--|--------------------------------|
| BIRTH NO. 65 13073 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13073 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| GILBERT N. SHELLEY | | DECEMBER 18 1965 3:40 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| FRANKLIN SQUARE HOSPITAL | | MARYLAND BALTIMORE CITY | | | |
| 100 CALHOUN, BALTIMORE 21223 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE 21218 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | |
| | | 2200 MARYLAND AVENUE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months Days |
| MALE | WHITE | DIVORCED | JUNE 15, 1913 | 52 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| EMPLOYED by Austin Packing Co. | | | | VIRGINIA | |
| 13. FATHER'S NAME (Type or Print) | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| LENWOOD F. SHELLEY | | ANN PERKINSON | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| UNKNOWN | | UNKNOWN | | BOLLING J. SHELLEY, BROTHER | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) GASTRO-INTESTINAL BLEEDING DUE TO ESOPHAGEAL VARICES | | 18 DAYS | |
| ANTECEDENT CAUSES | | (B) DUE TO PORTAL CIRRHOSIS | | UNKNOWN | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | BRONCHO PNEUMONIA, BILATERAL | | 5 DAYS | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/4 1965 to 12/18 1965, that (I) (we) last saw the deceased alive on 12/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| QUINTIN L. W. | | | | 12/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | Dec. 20/65 | | Blandford Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Petersburgh, Virginia | | DEC 23 1965 | | R. V. Singleton, Glen Burnie, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | | | | |

| BIRTH NO. <u>65 13074</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. <u>65 13074</u> | |
|--|--------------------|---|-------------------------------|---|---|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | |
| KENNETH HAIGHT | | | | 2. DATE AND HOUR PRONOUNCED DEAD 12/15/65 9:05 a. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | |
| 44 Union Memorial Hospital | | | | D. STREET ADDRESS (If rural, give location) 4409 Ivanhoe Ave. | | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 6-10-1965 | 9. AGE (In years last birthday) 6 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME George D. Haight | | | | 14. MOTHER'S MAIDEN NAME Carrie Ramseur | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. (If yes, give war or dates of service)) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS William Ramseur, Charles Town, W.Va. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration of stomach contents ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malnutrition | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/15/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12-18-1965 | | 23C. NAME OF CEMETERY or CREMATORY Fairview Cemetery | | 23D. LOCATION (City, town, or county) (State) Charles Town, W.Va. | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 24C. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md For Smith Funeral Home, Charles Town, W.Va. | | ADDRESS | |

WALLACE PRODUCE

WALLACE PRODUCE

FUNERAL DIRECTOR: IMPORTANT

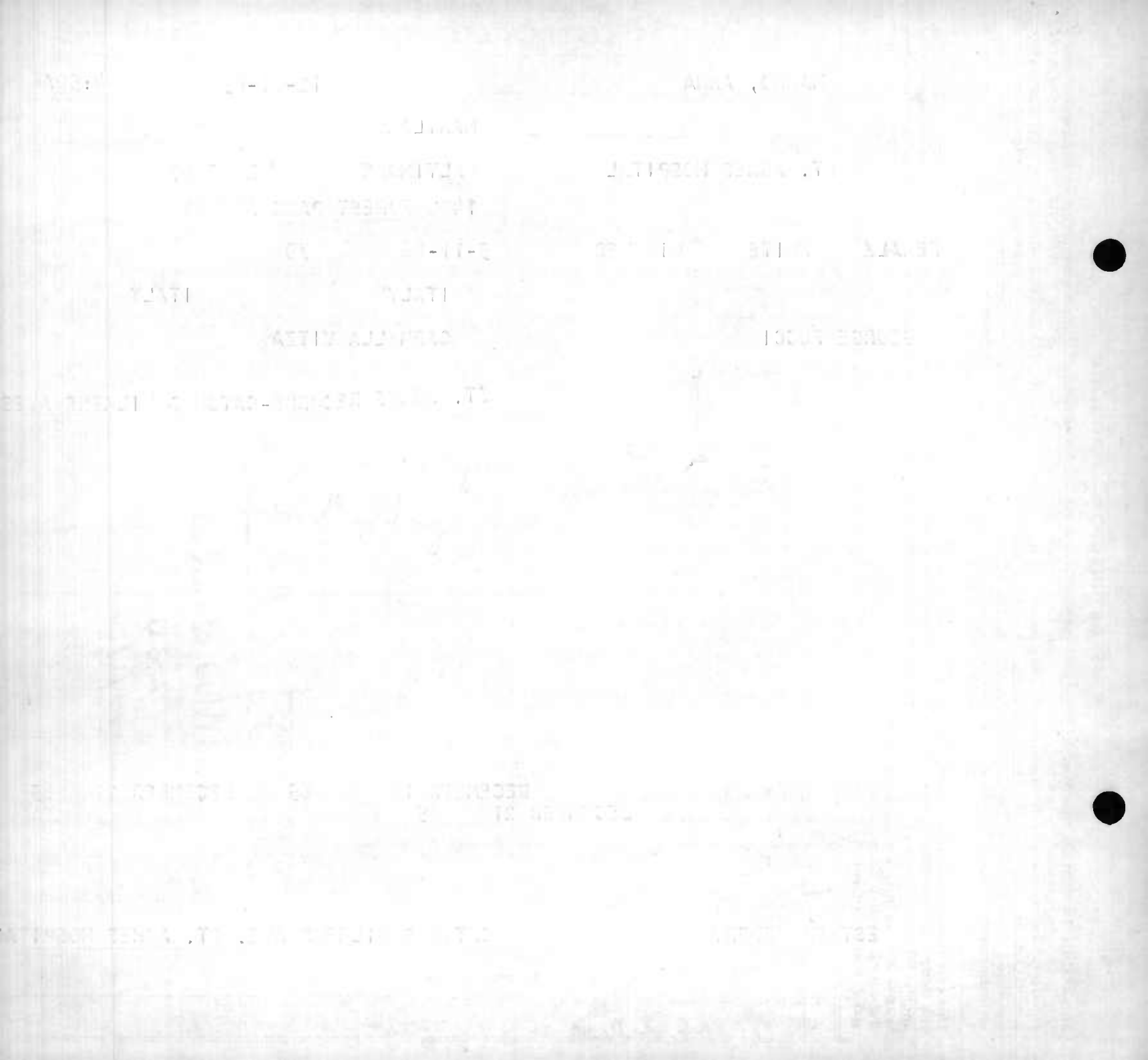
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|---|---|--|
| BIRTH NO. 1065 13075 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13075 | |
| 1. NAME OF DECEASED (Type or Print) MCGEE BERNARD J | | | 2. DATE AND HOUR OF DEATH 12-20-65 7:10AM M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTIMORE, MARYLAND 21229 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 117 UPMANOR ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11-26-13 | 9. AGE (In years lost birthday) 52 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES PROMOTOR | | 10B. KIND OF BUSINESS OR INDUSTRY HIRAM WALKER DIST. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME THOMAS E MCGEE (DEC) | | | 14. MOTHER'S MAIDEN NAME MARY SMITH (DEC) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Wife Dorothy McGee</i> ADDRESS ST. AGNES HOSPITAL RECORDS BALTO. 29, MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 296X I Pneumonia - Rt Middle and Lower lobe DUE TO Antecedent Causes Passive Congestion and subcapsular bleeding of lungs, liver, spleen and kidneys DUE TO Anemia, Thrombocytopenia | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 12-19 19 65 to 12-20- 19 65, that (X) (we) last saw the deceased alive on 12-20- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>E. Weiss</i> | | | | 23B. DATE SIGNED 12-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) E. WEISS | | 23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR R. E. ... | |
| 25C. FUNERAL DIRECTOR Wittke, W. 4101 Edmondson | | ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>65 13076</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 13076</u> | |
|--|--|--|--|---|--|--------------------------------|--|
| M.E. CASE NO. <u>1</u> | | | | 1. NAME OF DECEASED (Type or Print) <u>MANNO, ANNA</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>12-21-65</u> <u>4:50A M.</u> | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>ST. AGNES HOSPITAL</u> | | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> | | | |
| 5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED, NEVER MARRIED <u>WIDOWED</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>ZONE 07</u> | | | |
| 8. DATE OF BIRTH <u>5-11-86</u> 9. AGE (In years last birthday) <u>79</u> | | | | D. STREET ADDRESS (If rural, give location) <u>1400 FOREST PARK AVENUE</u> <u>63-00</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>ITALY</u> | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>ITALY</u> | | | |
| 13. FATHER'S NAME <u>GEORGE FUCCI</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CARMELLA VITZA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Ms. Lillian Suman daughter</u> | | | |
| 18. <u>434.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <u>Respiratory disorders</u> | | | |
| | | | | (B) <u>Congestive heart failure</u> | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) <u>NO</u> | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 19</u> <u>19 65</u> to <u>DECEMBER 21</u> <u>19 65</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 21</u> <u>19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Esther Edery</u> | | | | 23B. DATE SIGNED <u>12/21/65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>ESTHER EDERY</u> | | | | 23D. ADDRESS <u>CATON & WILKENS AVE. ST. AGNES HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>12/23/65</u> | | | |
| 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u> | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1965</u> | | | | 25B. NAME OF REGISTRAR <u>W. J. Edmonds</u> | | | |
| 25C. FUNERAL DIRECTOR <u>W. J. Edmonds</u> | | | | ADDRESS <u>4101 Edmonds Ave</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------------|--|----------------------------------|--|--|
| BIRTH NO. 65 13077 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13077 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Miss MARY P. INGLE Pechin | | 2. DATE AND HOUR OF DEATH DEC. 22, 1965 4:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 6-05 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL | | D. STREET ADDRESS (If rural, give location) Church Home | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married | 8. DATE OF BIRTH Dec. 20 1883 | 9. AGE (In years lost birthday) 82 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY Hospital for the Women of Maryland | | 11. BIRTHPLACE (State or foreign country) City Maryland Balto. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME J. Laurie Ingle, M. D. | | 14. MOTHER'S MAIDEN NAME Rebecca C. Addison | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. 228-42-9998 | | 17. INFORMANT ADDRESS Hospital Records and Miss Ingle (1965) S & M Co. records | |
| 18. 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) RECURRING CARCINOMA of URINARY Bladder (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION JUNE 10, 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of bladder | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JUNE 8 1965 to 12/22 1965, that (I) (we) lost saw the deceased alive on 12/22/65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Danilo V. Santos | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec. 22, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) DANILLO V. SANTOS | | 23D. ADDRESS CHURCH HOME + HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE Dec. 23/1965 | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR R. E. S. S. S. | | 25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co. 108 W. North Av. City | |

(Continued on next page)

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HERBERT

L. JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

December 22, 1965

9:00 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

724 Hilton Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11-1-1921

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEEL WORKER

10B. KIND OF BUSINESS OR INDUSTRY

STEEL MFG.

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

THOMAS WALKER

14. MOTHER'S MAIDEN NAME

CLARA Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

FLORA MAE JACKSON - 46 N. FRAZIER ST. Ph. 1, A

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Exsanguination
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Stab Wounds of Face, Back and Perineum.
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Front of 2121 Homewood Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 21 '65 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed during altercation.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/22/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal - Burial

23B. DATE

12-27-65

23C. NAME of CEMETERY or CREMATORY

Rose Hill

23D. LOCATION

(City, town, or county)

(State)

GASTONIA, NORTH CAROLINA

24A. DATE REC'D BY HEALTH DEPT.

DEC 23 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

MARSHALL W. JONES, JR.

ADDRESS

1735 HARFORD AVE.

VALLEY PARK

BIRTH NO. 65 13078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 13078

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES W. WESTLEY

2. DATE AND HOUR PRONOUNCED DEAD

12-19-65

2:30

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1436 ARGYLE AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1436 Argyle Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Dec. 4, 1881

9. AGE (In years
last birthday)

84

11 Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Marie Robinson 1436 Argyle Ave.

18. E 916.9

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) ~~XXXX~~Carbon monoxide poisoning with 3rd
degree burns

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1436 Argyle Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 19 '65 12:06 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR? Was confined to bed

Burned while smoking in bed 14-22

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-20-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23/65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 23 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Adelbert S. Phillips 1722 N. Monmouth

ADDRESS

RECEIVED
JAN 1 1891

THE
LIBRARY
OF THE
MUSEUM OF
COMPARATIVE ZOOLOGY
AT
HARVARD UNIVERSITY
CAMBRIDGE, MASS.

RECEIVED
JAN 1 1891

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 13080 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13080

M.E. CASE NO.

| | | | | | | | |
|---|---------|--|------------------|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| SIDNEY MURRAY | | | | 12-20-65 5:00 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL | | | | A. STATE Maryland | | | |
| (If not in hospital or institution, give street address or location) | | | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 2412 Barclay Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| Male | Colored | Married | Aug. 11, 1908 | 57 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | Porter | | New York | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Samuel Murray | | | | Learie Gray | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (Widow) | | ADDRESS | |
| | | | | Viola Murray | | 2412 Barclay St. | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| | | | | Multiple gunshot wounds | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | Hotel | | Armstead Hotel | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | (Hour) (Minute) | | | | | |
| 12 20 '65 | | 12:15 AM | | | | | |
| | | WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| | | | | Shot during robbery at hotel | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 12-20-65 | |
| RUSSELL S. FISHER, M.D. | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 12/23/65 | | Mount Calvary Cem. | | Arundel Co. Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 23 1965 | | Robert E. Fisher, M.D. | | I.L. Brown & Son | | 123 W. Montgomery St. | |

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Handwritten signature

1/23/01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-----------------------------|---|------------------------------------|--|---|
| BIRTH NO. 65 13081 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13081 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) McCARTHY, John Francis | | 2. DATE AND HOUR OF DEATH 12/22/65 | | 5:10 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Pennsylvania B. COUNTY Philadelphia C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-33 D. STREET ADDRESS (If rural, give location) 1337 South 49th Street | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 12/6/97 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Oper | | 10B. KIND OF BUSINESS OR INDUSTRY Public Conveyence | | 11. BIRTHPLACE (State or foreign country) Westminster, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William McCarthy | | | |
| 14. MOTHER'S MAIDEN NAME Elsie unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/19/42-3/16/43 | | | |
| 16. SOCIAL SECURITY NO. 166-03-4342 | | 17. INFORMANT VA Hospital records ADDRESS 3900 Loch Raven Blvd., Balto., Md 21218 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) 002.1 I Tuberculosis, Pulmonary, Far Advanced Active | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 11 months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (✓) (this hospital) attended the deceased from March 15th 19 65 to December 22nd 19 65 , that (✓) (we) lost saw the deceased alive on December 22nd 19 65 and that in (✓) (our) opinion death occurred on the date and hour and from the causes stated above. (✓) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE YOUNG E. CHUN | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) Young E. Chun | | 23D. ADDRESS VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD., BALTO., MD 21218 | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 12-27-65 | | 24C. NAME OF CEMETERY or CREMATORY U.S. National Cemetery | |
| 24D. LOCATION Beverly, New Jersey | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Sullivan | | 25C. FUNERAL DIRECTOR'S ADDRESS Ellsworth Armacost 4600 Liberty Heights | | | |

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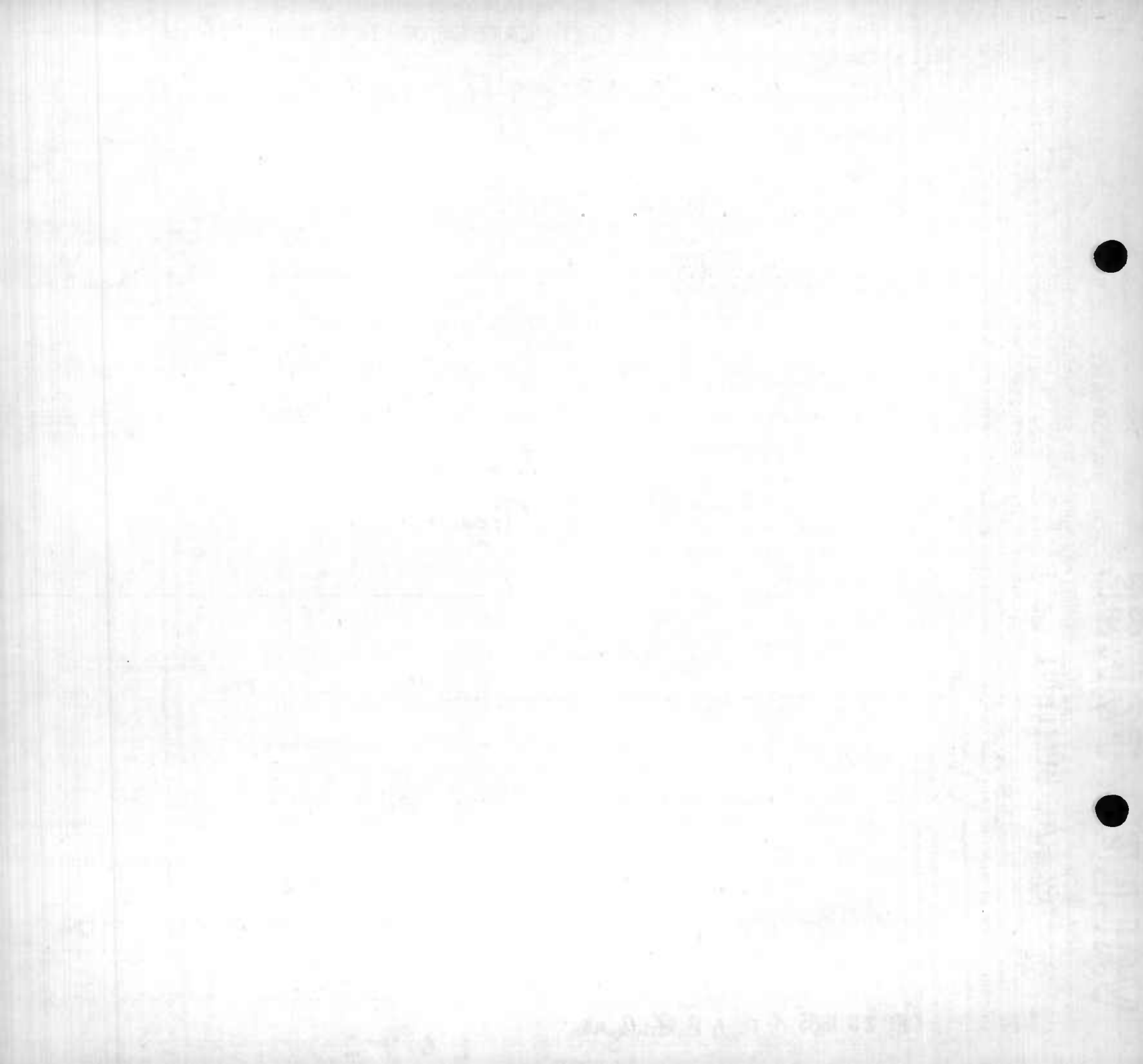
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

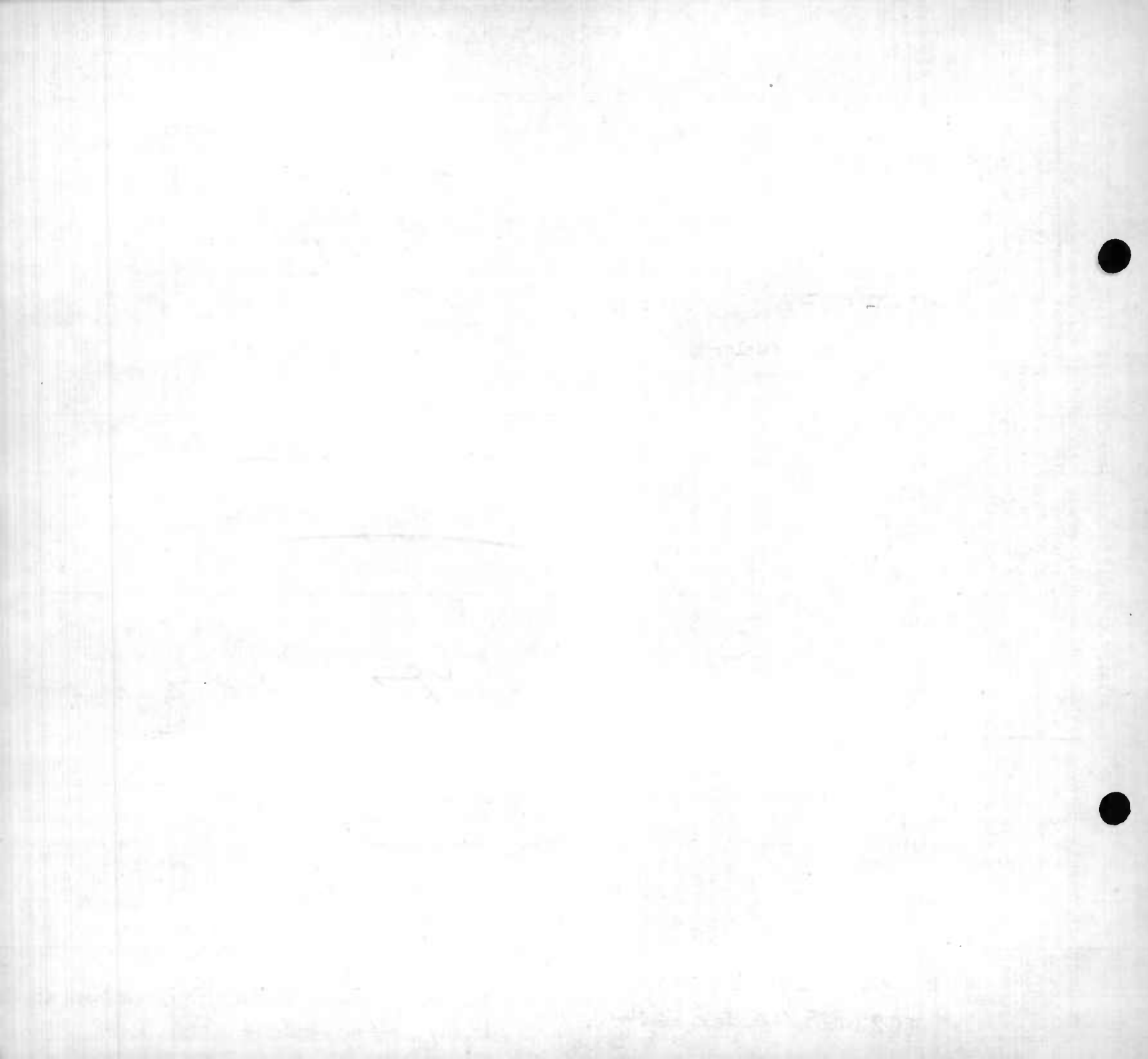
| BIRTH NO. 65-307865 13082 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13082 | |
|--|--|---|--|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Morris, "A" Baby boy Eartie Mae | | | | 2. DATE AND HOUR OF DEATH 12/19/65 9 50 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital 4940 Eastern Ave. Blato. Md. 21224 | | | | A. STATE B. COUNTY Md. 25-33 | | | |
| 5. SEX M | | | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | |
| 8. DATE OF BIRTH Dec. 14, 1965 | | | | 9. AGE (In years last birthday) 5 | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME | | | |
| 14. MOTHER'S MAIDEN NAME Morris, Eartie Mae | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | | | |
| 18. 771.5T DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Pulmonary Hemorrhage DUE TO (B) Prematurity DUE TO (C) | | | |
| INTERVAL BETWEEN ONSET AND DEATH 12 hrs. | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Pending | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1965 to Dec. 19, 1965, that (I) (we) last saw the deceased alive on Dec. 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Jere B. Smith | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) Jere B. Smith | | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore City, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12-22-65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

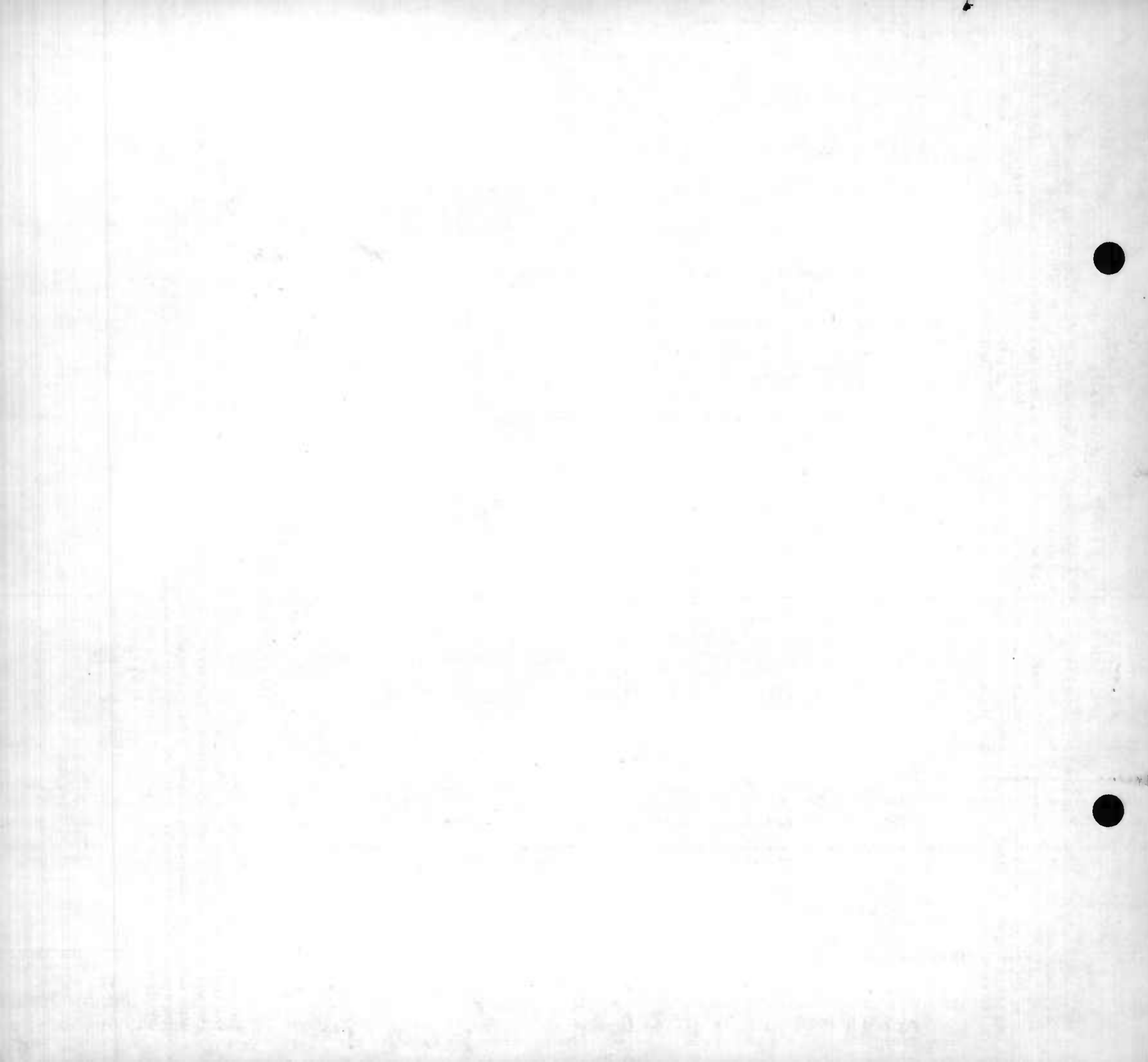
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|--|---|---|---|--|--|
| BIRTH NO. 65 13083 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13083 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Hilda D. Gerhardt | | 2. DATE AND HOUR OF DEATH 21-Dec 65 11 40p M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL Hospital | | | A. STATE MARYLAND B. COUNTY Baltimore | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Loch Raven Village 53-00 | | |
| D. STREET ADDRESS (If rural, give location) 8301 Loch Raven Blvd | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 10-1-92 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Attorney | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME FRANK GUSLER | | | 14. MOTHER'S MAIDEN NAME ANNA MORELOCK | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital - Chart | |
| 18. 13-3-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) Metastatic Carcinoma of Colon DUE TO (B) CARCINOMA OF COLON DUE TO EXACT SITE UNKNOWN (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 20 Oct 65 19 65 to 21-Dec 19 65 , that (2) (we) last saw the deceased alive on 21 Dec 19 65 and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE T.C. Callis | | | | 23B. DATE SIGNED 21-Dec-65 | |
| 23C. PHYSICIAN'S NAME (Type) T.C. Callis | | | | 23D. ADDRESS MARYLAND GENERAL Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 12/24/1965 | | 24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Plant City, Florida | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Wm. F. ... | |
| 25D. ADDRESS Bulky ... North ... | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 13084 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13084 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Alberta Nichols</i> | | 2. DATE AND HOUR OF DEATH <i>12/21/65 6:35 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i> Md. </i> B. COUNTY <i> 19-01 </i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore # 23</i> | |
| D. STREET ADDRESS (If rural, give location) <i>310 N. Carey St.</i> | | 5. SEX <i> F </i> | | 6. RACE <i> C </i> | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | | 8. DATE OF BIRTH <i>11/6/97</i> | | 9. AGE (In years last birthday) <i>68</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i> Md. </i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i> U.S. </i> | | 13. FATHER'S NAME <i>unk</i> | | 14. MOTHER'S MAIDEN NAME <i>unk</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Rev. Theodore Jackson</i> | |
| ADDRESS <i>410 N. Calhoun</i> | | 18. <i>45-6X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <i>Systemic Lupus Erythematosus</i> DUE TO (B) DUE TO (C) DUE TO | |
| INTERVAL BETWEEN ONSET AND DEATH <i>3 wks.</i> | | 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>December 3, 1965</i> to <i>December 21, 1965</i> , that (we) last saw the deceased alive on <i>December 20, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | |
| 23A. SIGNATURE <i>Bernard du Buy</i> M.D. | | 23B. DATE SIGNED <i>12/21/65</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Bernard du Buy</i> M.D. | |
| 23D. ADDRESS <i>University Hospital</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/24/65</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>Carver Mem. Park</i> | | 24D. LOCATION (City, town, or county) (State) <i>Prince George County, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 23 1965</i> | |
| 25B. NAME OF REGISTRAR <i>R. B. E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>W. M. G. MARCH</i> | | ADDRESS <i>928 E. North Ave</i> | |



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| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|--|--|
| BIRTH NO. 65 13085 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13085 | |
| M.E. CASE NO. | | 2. DATE AND HOUR PRONOUNCED DEAD 12/19/65 4:15 a. M. | |
| 1. NAME OF DECEASED (Type or Print) CHARLES LANEY | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 877 W. Fayette St. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital | | 5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | |
| 18. E983X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia, complicating craniocerebral injury ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | |
| 21D. TIME OF INJURY (APPROX.) 12 12 65 ? | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? beaten | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/19/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/23/65 | |
| 23C. NAME OF CEMETERY or CREMATORY Mt. Calvary | | 23D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 24B. NAME OF REGISTRAR Robert E. Jenkins, MA | |
| 24C. FUNERAL DIRECTOR Lura P. Swartz | | 24D. ADDRESS 1712 W. North Ave | |

WALLER BOONE

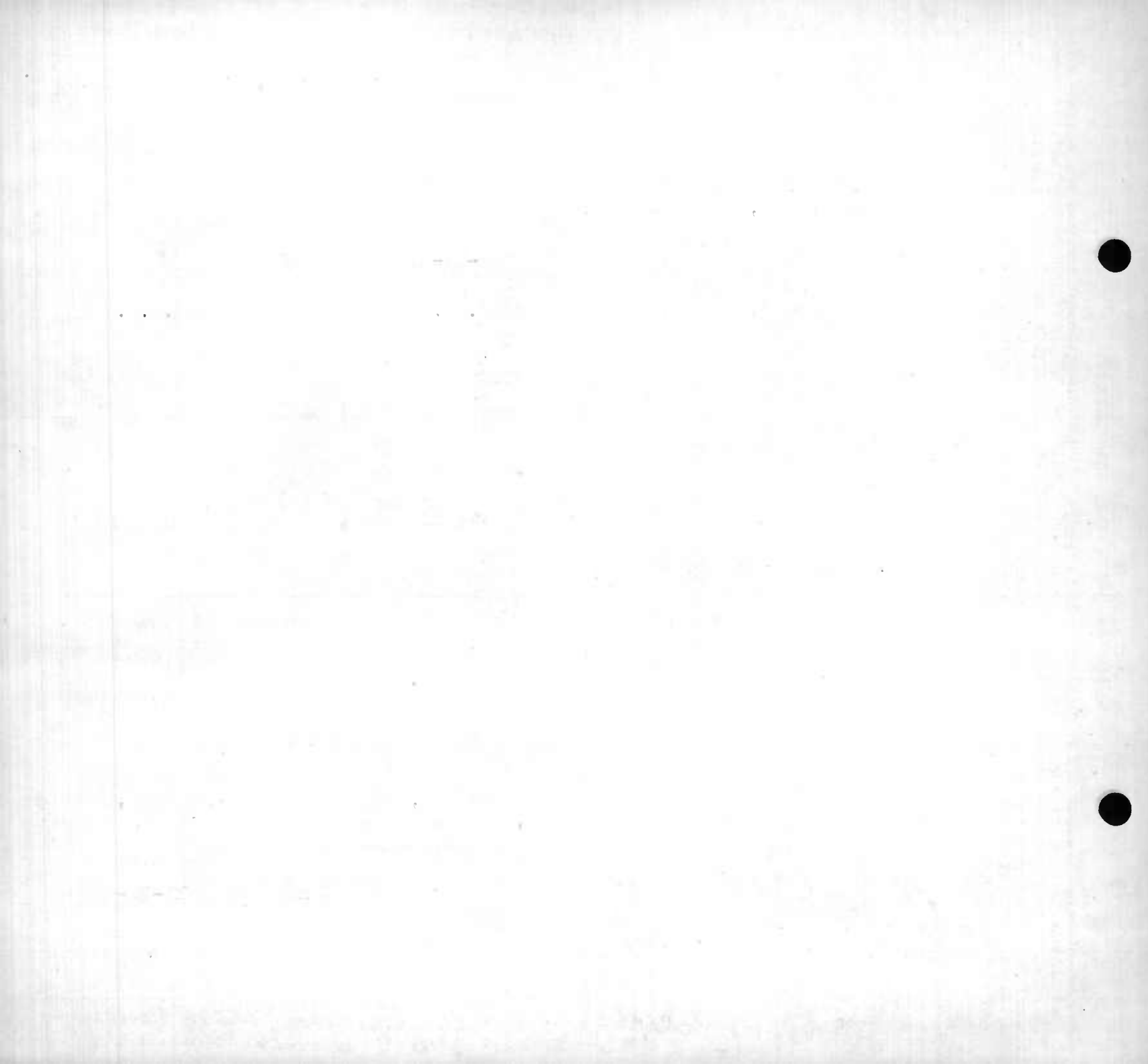
AND COMPANY

Recd 10/25/22 Mr. Collier &
Mrs. Boone 11/1/22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

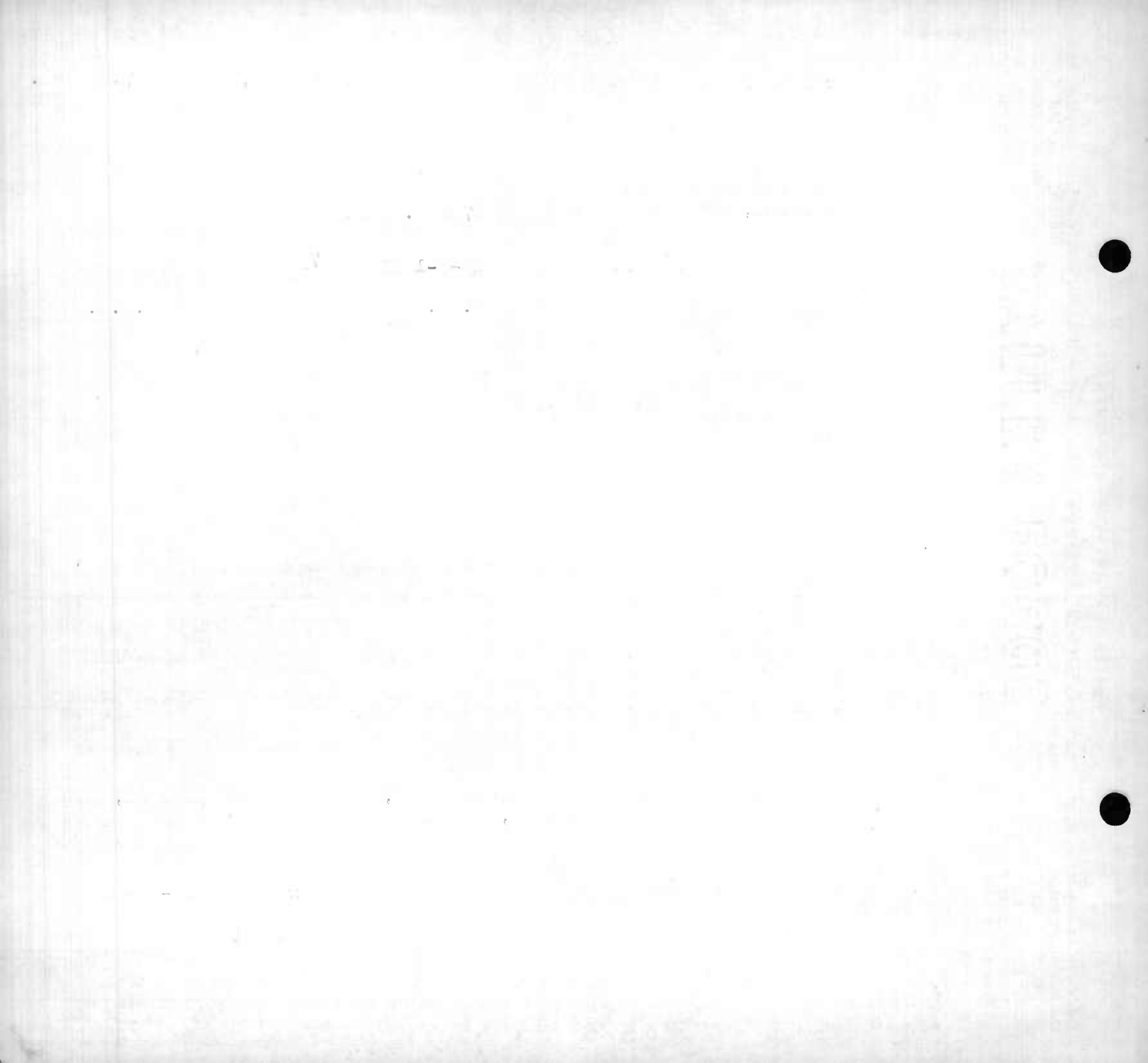
| | |
|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT Registered No. 65 13086 | |
| CERTIFICATE OF DEATH | |
| BIRTH NO. 65 13086 | |
| M.E. CASE NO. _____ | |
| 1. NAME OF DECEASED (Type or Print) Caiphus Mills | |
| 2. DATE AND HOUR OF DEATH December 20, 1965 10:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 804 McKean Avenue | |
| 5. SEX Male | 6. RACE Negro |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2-14-1900 |
| 9. AGE (In years lost birthday) 65 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. BIRTHPLACE (State or foreign country) S. C. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John G. Mills | 14. MOTHER'S MAIDEN NAME Sarah Fair |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 217-65-1881 |
| 17. INFORMANT Mrs. Eleanor Mills 804 McKean Ave. | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive C.V. Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION 0 | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No. | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 19, 1965 to December 20, 1965 , that (I) (we) last saw the deceased alive on December 20, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE H. Harold Churchill M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) H. G. Churchill | |
| 23D. ADDRESS 1514 Division Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE Dec 24, 1965 | |
| 24C. NAME OF CEMETERY or CREMATORY Archutus Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Archutus (Baltimore) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | |
| 25B. NAME OF REGISTRAR John A. B. Taylor | |
| 25C. FUNERAL DIRECTOR Joseph L. Ross | |
| ADDRESS 2222 W. North Ave. Baltimore, Md. | |



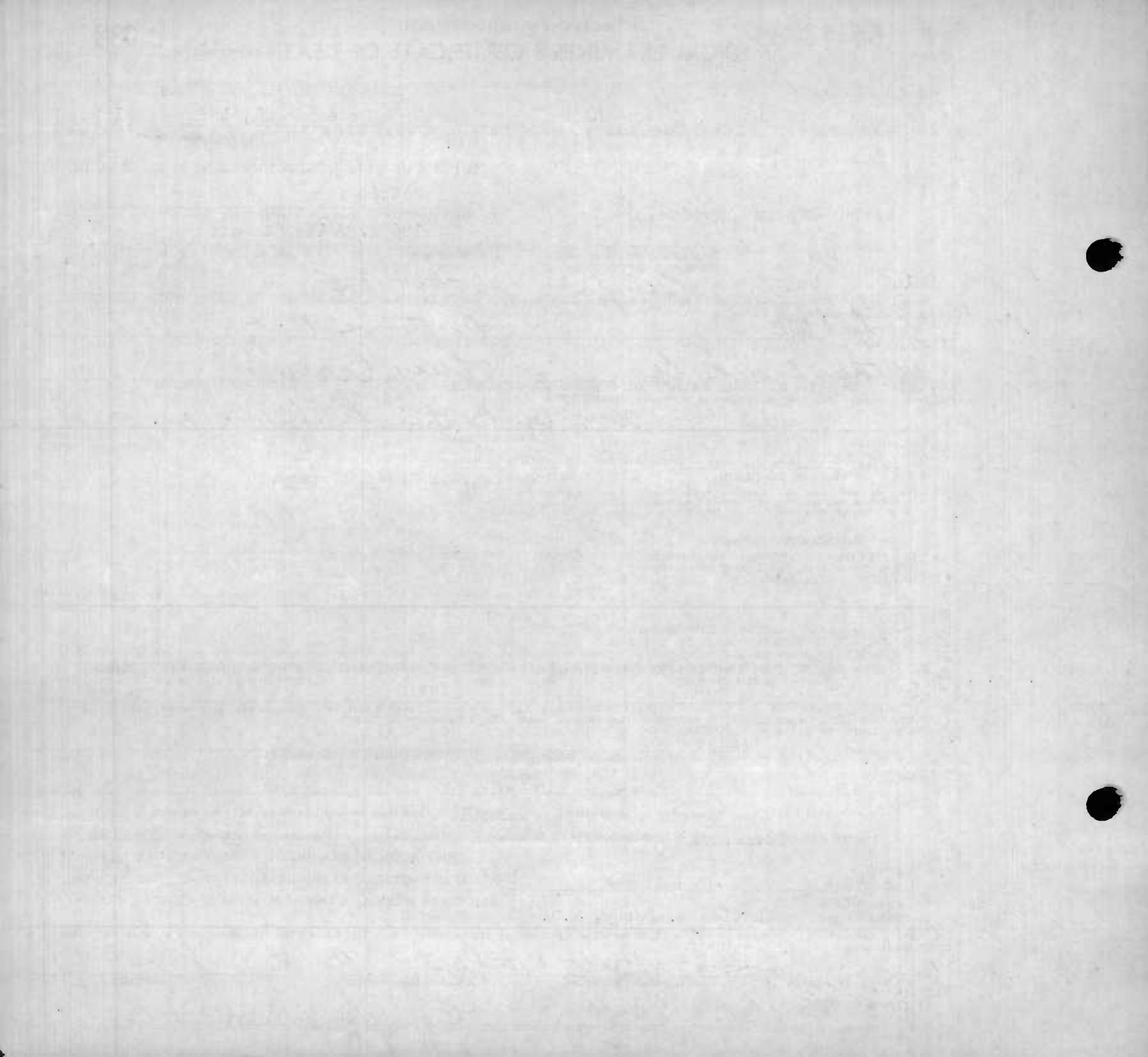
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|--|---------------------------------------|--|---|--|------------------------------|--|--|
| BIRTH NO. 65 13087 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 13087 | | | | |
| 1. NAME OF DECEASED (Type or Print) Sadie Berland (Breland) | | | | | 2. DATE AND HOUR OF DEATH December 21, 1965 7:00 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland | | | | | A. STATE Maryland B. COUNTY 15-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2701 W. North Avenue | | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-5-1892 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) N. C., Fayetteville | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Clarence McDonald | | | | | 14. MOTHER'S MAIDEN NAME Janice Lowell | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 24-34-6811 | | 17. INFORMANT Marie Williams 2830 Pishany St. | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 260X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) DUE TO Hypertensive Heart Disease (B) DUE TO Diabetes Mellitus (C) DUE TO Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 20, 1965 to December 21, 1965, that (I) (we) last saw the deceased alive on December 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE R. Theodore | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-21-65 | | |
| 23C. PHYSICIAN'S NAME (Type) ROGER THEODORE | | | | | 23D. ADDRESS M.D. 1514 Division Street | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 24, 1965 | | 24C. NAME of CEMETERY or CREMATORY Arboretum Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore (Baltimore) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR R. A. Theodore | | 25C. FUNERAL DIRECTOR Joseph R. Russ | | ADDRESS 2222 N. Mount Greer Baltimore, Md. | | | |



| | | | | | |
|---|---------|---|---|--|--|
| 65 13088 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13038 | |
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| ARTHUR L. BLACK | | | December 21, 1965 | | 1:26 P.M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE Maryland | | |
| 33 Johns Hopkins Hospital | | | B. COUNTY Baltimore | | |
| D. STREET ADDRESS (If rural, give location) | | | 106 N. Wolfe Street | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Male | Negro | Single | 10-26-1925 | 40 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Labor | | | | Baltimore Md | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Arthur Black Sr | | | Lucy Craig | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| YES | | | 213-30-6866 | | Beatrice Leach 11911 Chapel St |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| I 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Heart Disease. DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 12/22/65 | |
| Charles S. Petty, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12-24-65 | | Balto Nat Cent | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| DEC 23 1965 | | Robert E. Fisher, M.D. | | Choy A. Wilson 1000 Bianty St | |



FUNERAL DIRECTOR: IMPORTANT

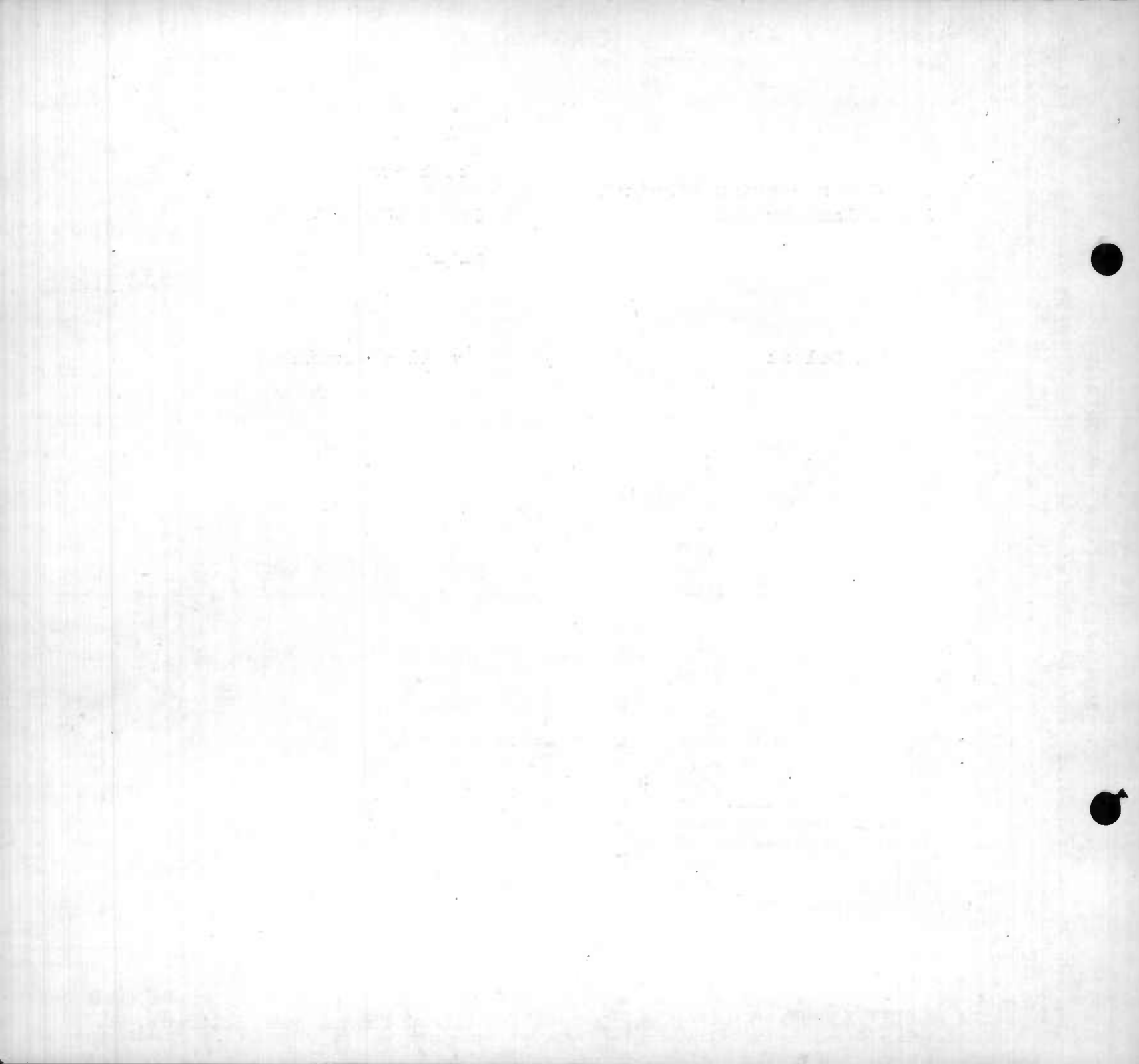
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|---|---|--|
| BIRTH NO. 65 13089 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13089 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | |
| (Type or Print) SARAH MYERS | | | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | Dec. 21, 1965 11:30p M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| 2652 Edmondson Ave. | | | | A. STATE Maryland | |
| | | | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 2652 Edmondson Ave. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Female | Negro | Widowed | Nov. 16, 1877 | 88 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | Va. | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| William Washington | | | Mary Sewell | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | | Linwood Hayes 2652 Edmondson Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 331X I | | (A) CRAMPED, 7 days of an. Accident | | 7 days. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| O | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/24/65 to 12/21/65, that (I) (we) last saw the deceased alive on 12/21/65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. Preston Grant | | | | 12/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| J. Preston Grant | | 601 N. Carrollton Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/26/65 | | Church Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Smithfield, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 23 1965 | | Robert E. [Signature] | | George H. Khan 1348 N. Calhoun St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

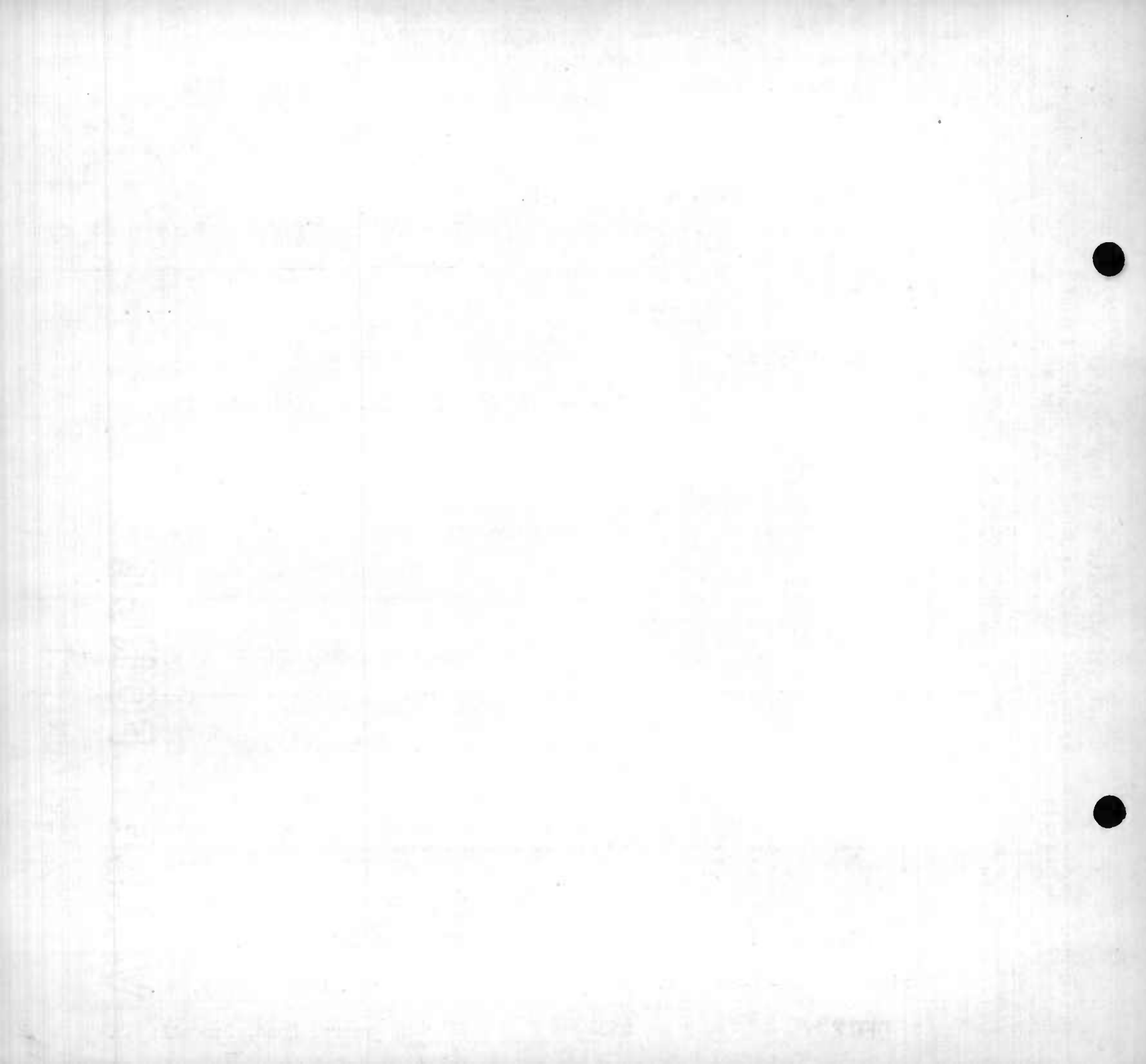
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|---|--------------|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | X | | Registered No. 65 13090 | |
| BIRTH NO. 65 13090 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FRED DELOST | | 2. DATE AND HOUR OF DEATH 12-21-65 6:35 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Ohio B. COUNTY V-32 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital 344 POLAND AVENUE | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Struthers | |
| | | D. STREET ADDRESS (If rural, give location) 344 Poland Avenue | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 3-1-31 | 9. AGE (In years last birthday) 34 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker |
| | | 10B. KIND OF BUSINESS OR INDUSTRY Real Estate | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME George Delost | | | 14. MOTHER'S MAIDEN NAME Pauline Grznick | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Mrs. Catherine Delost Struthers, O. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 754.01 | | CAUSE OF DEATH (A) Congenital Heart Disease (B) (Patology of Fallot) (C) Congestive Heart Failure | | INTERVAL BETWEEN ONSET AND DEATH since birth | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-7-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Congenital heart disease | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-29-65 19 to 12-21-65 19, that (I) (we) last saw the deceased alive on 12-20-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Edward Taylor M.D. | | | | 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) EDWARD TAYLOR | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY or CREMATORY St. John's | |
| | | | | 24D. LOCATION (City, town, or county) (State) Campbell, Ohio | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR John E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | Registered No. 65 13091 | |
|---|-----------------------------|---|---------------------------------------|---|---|--|---|
| BIRTH NO. 65 13091 | | CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANTTI WM. KYLMALA | | | | 2. DATE AND HOUR OF DEATH 18 December 1965 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Md. | | B. COUNTY Baltimore | |
| House in the Pines, Belvedere N. H. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 12 Southship Rd. | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 3 Apr 1892 | 9. AGE (In years last birthday) 73 | 11. BIRTHPLACE (State or foreign country) Finland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) heater | | 10B. KIND OF BUSINESS OR INDUSTRY Steel | | 13. FATHER'S NAME Antti Kylmala | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213-09-4377 | | 17. INFORMANT ADDRESS Aili Kylmala, 12 Southship 21222 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 43-0-01 TOXEMIA INFECTIO BEDRUP RENAL FAILURE | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 10 yr. | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | (B) DUE TO | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 8 1965 to Dec 18 1965 , that (I) (we) last saw the deceased alive on Dec 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Lester Kolman M.D. | | | | 23B. DATE SIGNED 12/20/65 | | 23C. PHYSICIAN'S NAME (Type) M. A. | |
| 23D. ADDRESS 3700 Park Heights Ave. | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12-22-65 | |
| 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR Adrian E. J. J. J. | | 25C. FUNERAL DIRECTOR Ulrich | | 25D. ADDRESS Funeral Home, Dundalk, Md. | |



65 13092

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13092

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALICE

BELLEW

2. DATE AND HOUR PRONOUNCED DEAD

December 20, 1965

7:15 P.^{M.}

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore (rural)

D. STREET ADDRESS (If rural, give location)

333 Harlem Lane

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

May 17, 1910

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Nursing Home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Emmett Schindell 231 Patapsco Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Rt. 40, W. of Old Frederick Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 20 '65 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by truck.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M/D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23.65

23C. NAME of CEMETERY or CREMATORY

Rock Gate Cemetery

23D. LOCATION

(City, town, or county)

Crozet, Va.

24A. DATE REC'D BY HEALTH DEPT.

DEC 23 1965

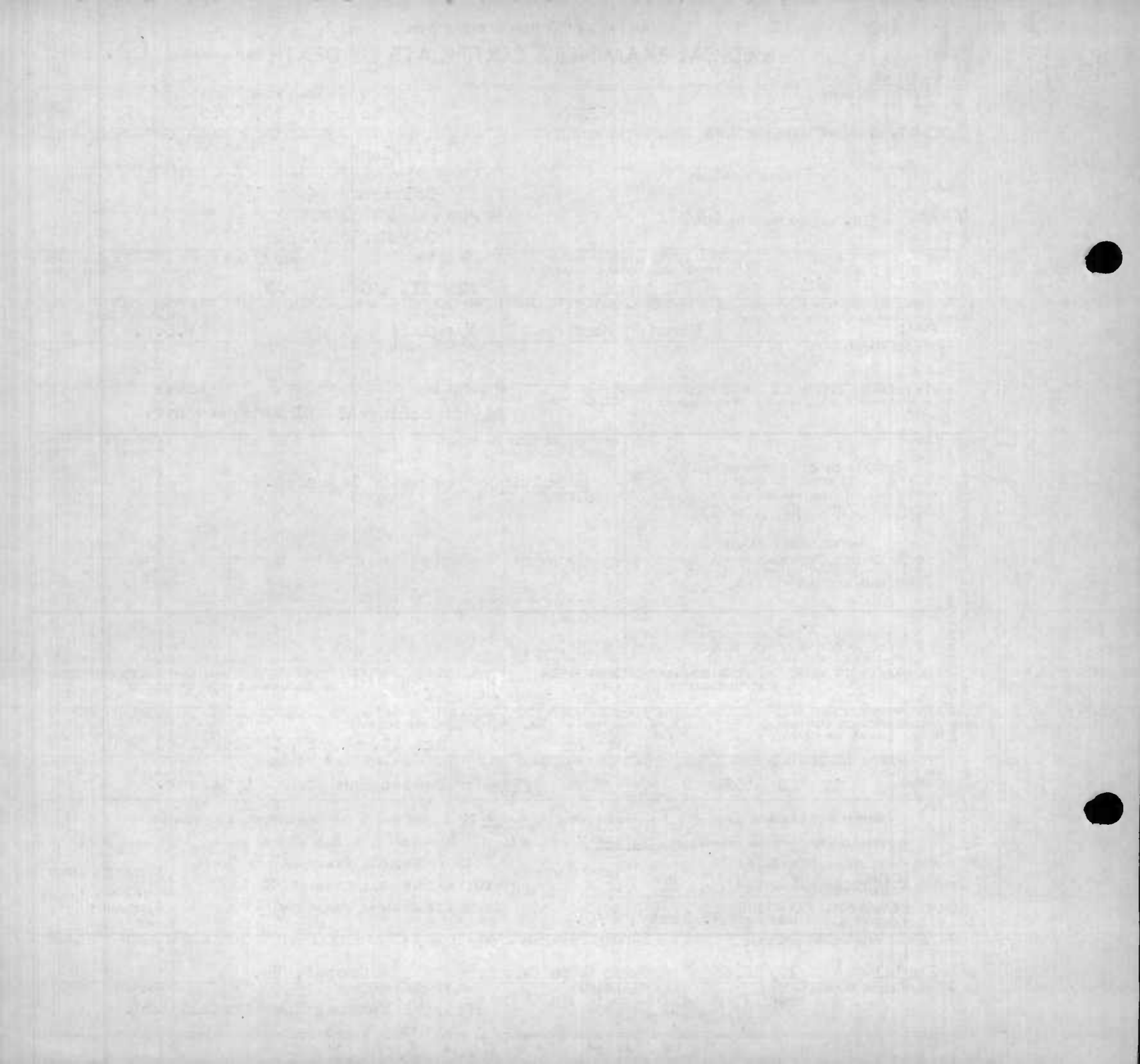
24B. NAME OF REGISTRAR

Robert E. Petty, M.D.

24C. FUNERAL DIRECTOR

Ullrich Funeral Home Dundalk, Md.

ADDRESS



CERTIFICATE OF DEATH

Registered No.

65 13093

BIRTH NO.

65 13093

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

PETER

LYSIONER (LYSIONOK)

2. DATE AND HOUR OF DEATH

Dec. 21, 1965

13 15

A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

(Rural)

53-00

D. STREET ADDRESS (If rural, give location)

7122 Sollers Point Road

21222

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)
Single

8. DATE OF BIRTH

6-5-90

9. AGE (In years
last birthday)

75 75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Threader

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Lysionok

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

215-09-1038

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18. 600.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Cardio circulatory collapse 1 day

(B) DUE TO

? SEPSIS 1 d.

(C) DUE TO

PYELONEPHRITIS 3 wks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic CV Disease YEARS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 28 19 65 to Dec. 21 19 65,
that (I) (we) lost saw the deceased alive on Dec. 21 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Barry Wayne Ullrich

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

Dec. 21, 1965

23C. PHYSICIAN'S
NAME (Type)

BARRY WAYNE ULLRICH

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-24-65

24C. NAME OF CEMETERY or CREMATORY

Russian Orthodox

24D. LOCATION

(City, town, or county)

Howard Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 23 1965

25B. NAME OF REGISTRAR

R. E. E. E. E.

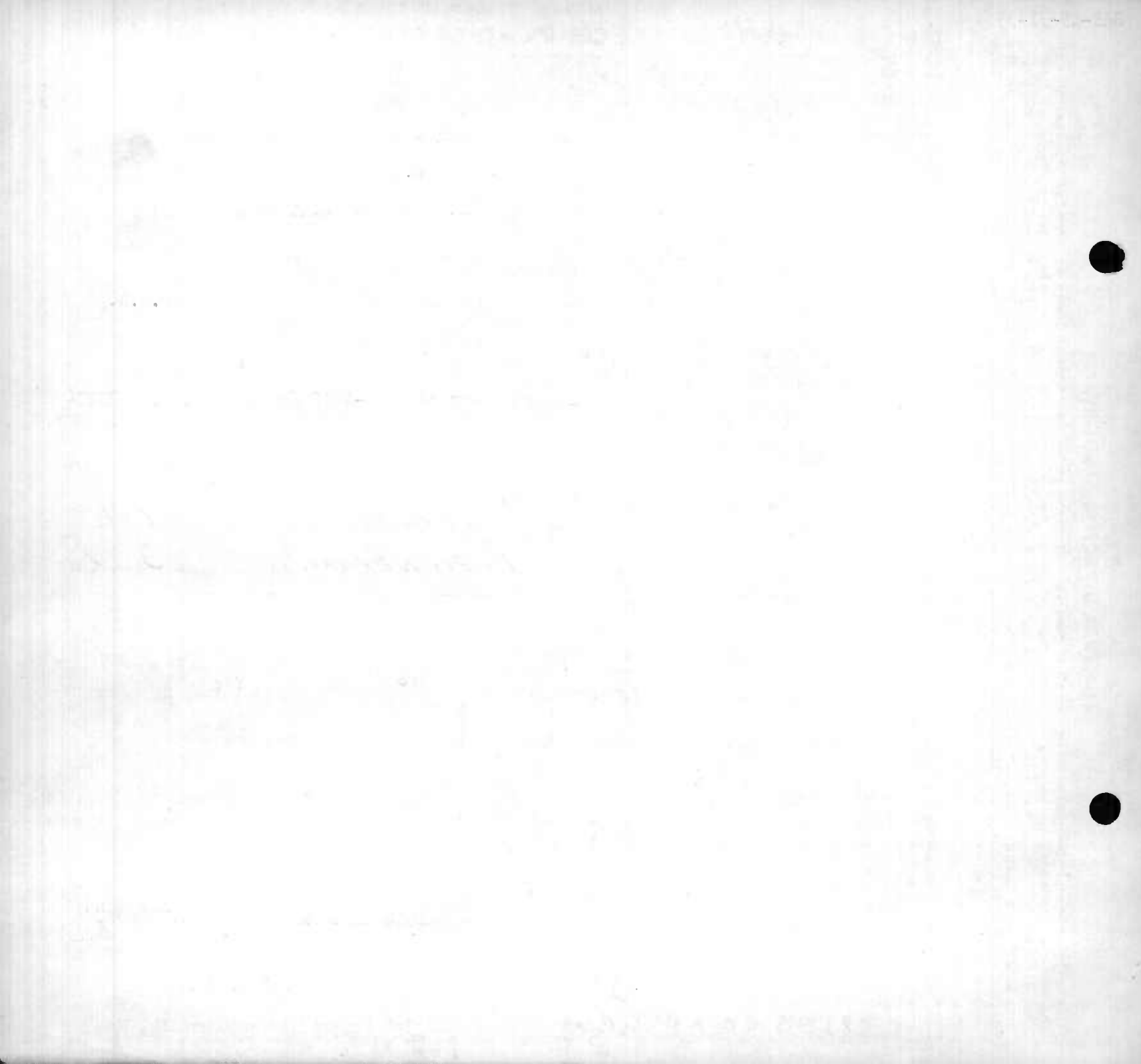
25C. FUNERAL DIRECTOR

Ullrich Funeral Home Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



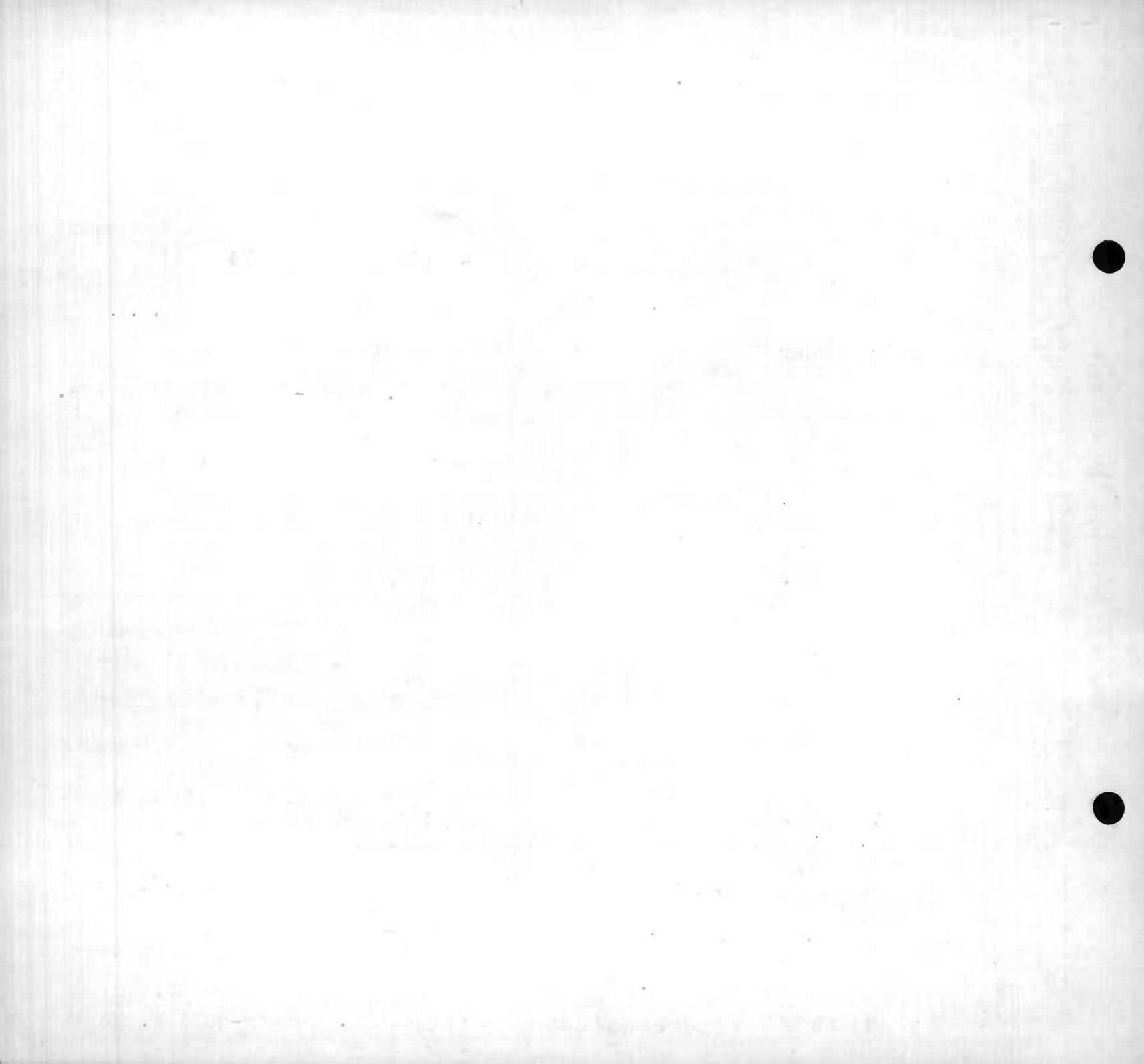
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13094 | |
|--|-----------|--|---------------------------|---|--|
| BIRTH NO. 65 13094 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Ernestine Kittrell Oden | | 2. DATE AND HOUR OF DEATH 12-21-65 12 07 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSP. OF MD 730 ASHBURTON ST. | | A. STATE Md. 16-07 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3006 GRAYSON ST. | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 4-19-32. | 9. AGE (In years last birthday) 33 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Co. Comfort Spring | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Abram Kittrell | | 14. MOTHER'S MAIDEN NAME Dora Burney | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Ruby Jones 1600 Rosedale ST. | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) SUBARACHNOID HEMORRHAGE DUE TO | | 7 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) HYPERTENSION PROBABLY ESSENTIAL DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-17-1965 to 12-21-1965, that (I) (we) last saw the deceased alive on 12-21-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Florahaida Reroma | | | | 23B. DATE SIGNED 12/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) Florahaida Reroma | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave. | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 13095 | |
|---|--|--|--|--|--|---|--|
| BIRTH NO. 65 13095 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Amanda B. Thomas | | | | 2. DATE AND HOUR OF DEATH 12-21-65 8 ¹² P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | A. STATE MARYLAND B. COUNTY 15-38 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3502 FAIRVIEW AVENUE #21216 | | | |
| 5. SEX F | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 3-18-91 | |
| 9. AGE (In years last birthday) 74 | | 10. AGE (In years last birthday) 74 | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | 10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family | | | |
| 13. FATHER'S NAME Ellis Bowser | | | | 14. MOTHER'S MAIDEN NAME Pleasant ? ? ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | Janie T. Davis-3502 Fairview Ave. RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Congestive heart failure | | | |
| | | | | (B) ASCVD 22 years | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CVA and MI 22 years | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 12-9-65 to 12-21-65, that (1) (we) lost saw the deceased alive on 12-21-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Alan E. Oestrich | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. ALAN E. OESTRICH | | | | 23D. ADDRESS 4940 EASTERN AVENUE #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery | | 24D. LOCATION (City, town, or county) Anne Arundle Co. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13096 | |
|--|--|--|---|--|--|
| BIRTH NO. 65 13096 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) IDA LEWIS | | 2. DATE AND HOUR OF DEATH 12/22/65 10¹⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 6-03 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 2234 ORLEANS ST. | | |
| 5. SEX F | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 3-16-1884 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME P | | | |
| 14. MOTHER'S MAIDEN NAME Mary Thompson | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) M | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Rosella Mason ADDRESS 1712 E. 4th St. N. H. Bk. | | | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) ARTERIOSCLEROTIC HEART DISEASE DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 12/21 19 65 to 12/22 19 65 , that (I) last saw the deceased alive on 12/22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Herbert A. Kushner M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) HERBERT A. KUSHNER | | | | 23D. ADDRESS University Hospital, Balto. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 12-27-65 | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cent | 24D. LOCATION (City, town, or county) (State) Brooklyn Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 23 1965 | 25B. NAME OF REGISTRAR Robert E. Jenkins | 25C. FUNERAL DIRECTOR Chey W. Wilson ADDRESS 1000 Brantley Ave | | | |

WALTER R. KRAMER

Robert C. Kahn

1955

1951

1950

1948

*

University of California, Berkeley

UNIVERSITY OF CALIFORNIA

Berkeley

2534 Channing St.

1950

1950

1950

1950

1950

1950

1950

BIRTH NO.

M.E. CASE NO.

5

13397

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65

13397

1. NAME OF DECEASED
(Type or Print)

ERNEST

HORTON

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1965

7:45 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Mt. Rainier

D. STREET ADDRESS (If rural, give location)

3155 Queens Chapel Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct 3, 1914

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Electrician

10B. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Cedric Horton

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W W 11

16. SOCIAL
SECURITY NO.

241 09 5073

17. INFORMANT

ADDRESS

Elizabeth S Horton Mt Rainier, Md.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec 24, 1965

23C. NAME of CEMETERY or CREMATORY

Arlington National

23D. LOCATION

(City, town, or county)

(State)

Arlington Va.

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1965

24B. NAME OF REGISTRAR

Robert E. Petty, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

F Gasch's Sons Hyattsville, Md.

WALTER H. ROSE

IN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13098 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13098 | |
|--|---------------------|--|------------------------------------|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Norman S. Disney</i> | | | | 2. DATE AND HOUR OF DEATH <i>25 Dec 65 6:20 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hospital of Baltimore</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3019 Matthews St</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i> | 8. DATE OF BIRTH <i>5/22/13</i> | 9. AGE (In years last birthday) <i>52</i> | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel Worker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Norman P. Disney</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Catherine Helen Henderson</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>213-09-1636</i> | | 17. INFORMANT <i>Ruth B. Reed Disney (Wife)</i> | | ADDRESS <i>Same</i> | |
| 18. <i>152.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Liposarcoma, metastatic</i> DUE TO (B) <i>Liposarcoma of duodenum</i> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <i>(X)</i> (this hospital) attended the deceased from <i>22 Nov 19 65</i> to <i>25 Dec 19 65</i> , that <i>(X)</i> (we) last saw the deceased alive on <i>25 Dec 19 65</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Solomon Robbins</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>25 Dec 65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Solomon Robbins</i> | | | | 23D. ADDRESS M.D. <i>Sinai Hospital of Baltimore.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/28/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Dulaney Valley Memorial Gardens</i> | | 24D. LOCATION (City, town, or county) (State) <i>Cockeysville, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>R. E. J. [Signature]</i> | | 25C. FUNERAL DIRECTOR <i>Eugenia K. Seitz</i> | | ADDRESS <i>5209 York Rd. Seitz Funeral Home Baltimore, 21212</i> | |

22

2/10/12

Wm. H. H. H.

2/10/12

2/10/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|--|--|--|---|---|--|--|--|-------------------------|
| 65 13099 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 13099 |
| 1. NAME OF DECEASED (Type or Print) <u>EDGAR E. SELLERS</u> | | | | | 2. DATE AND HOUR OF DEATH <u>Dec 17, 1965</u> <u>9:30 P.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Carroll</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Manchester</u> <u>5600</u> D. STREET ADDRESS (If rural, give location) | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH <u>12/14/04</u> | 9. AGE (In years last birthday) <u>61</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | |
| 13. FATHER'S NAME <u>Noah D.G. Sellers</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Schaeffer</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | | | 16. SOCIAL SECURITY NO. <u>220-24-6919</u> | | 17. INFORMANT <u>Mr. Alice Sellers, Manchester Md.</u> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>360.4</u> <u>RENAL FAILURE</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>9 Days</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>2 Mediastinitis</u> <u>2 Perforated Esophagus</u> | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>12-8-65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hiatal Hernia</u> | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-16-65</u> 19 to <u>12-17</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-17-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>John H. Jewell</u> M.D. | | | | | 23B. DATE SIGNED <u>12-17-65</u> | | | 23C. PHYSICIAN'S NAME (Type) <u>John H. Jewell</u> M.D. | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-20-65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Lineboro Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Lineboro, Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jewell</u> | | 25C. FUNERAL DIRECTOR <u>Tipton-Eline</u> | | 25D. ADDRESS <u>Hampstead, Md.</u> | | | | |

Markland

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 13100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 13100

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE Hoffmann

2. DATE AND HOUR PRONOUNCED DEAD

12/19/65 9:55 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1643 Ralworth Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

Feb. 21, 1927

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Funeral Director

10B. KIND OF BUSINESS OR INDUSTRY

Self employed

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Clarence Hoffmann

14. MOTHER'S MAIDEN NAME

Margaret Weber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

212-28-6973

17. INFORMANT

ADDRESS

Mrs. Thelma Hoffmann 1643 Ralworth Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carbon Monoxide Poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Garage

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1643 Ralworth Road

21D. TIME
OF INJURY
(APPROX.)

12

19

65

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Inhaled carbon monoxide

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-23-65

23C. NAME OF CEMETERY or CREMATORY

Oakland Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

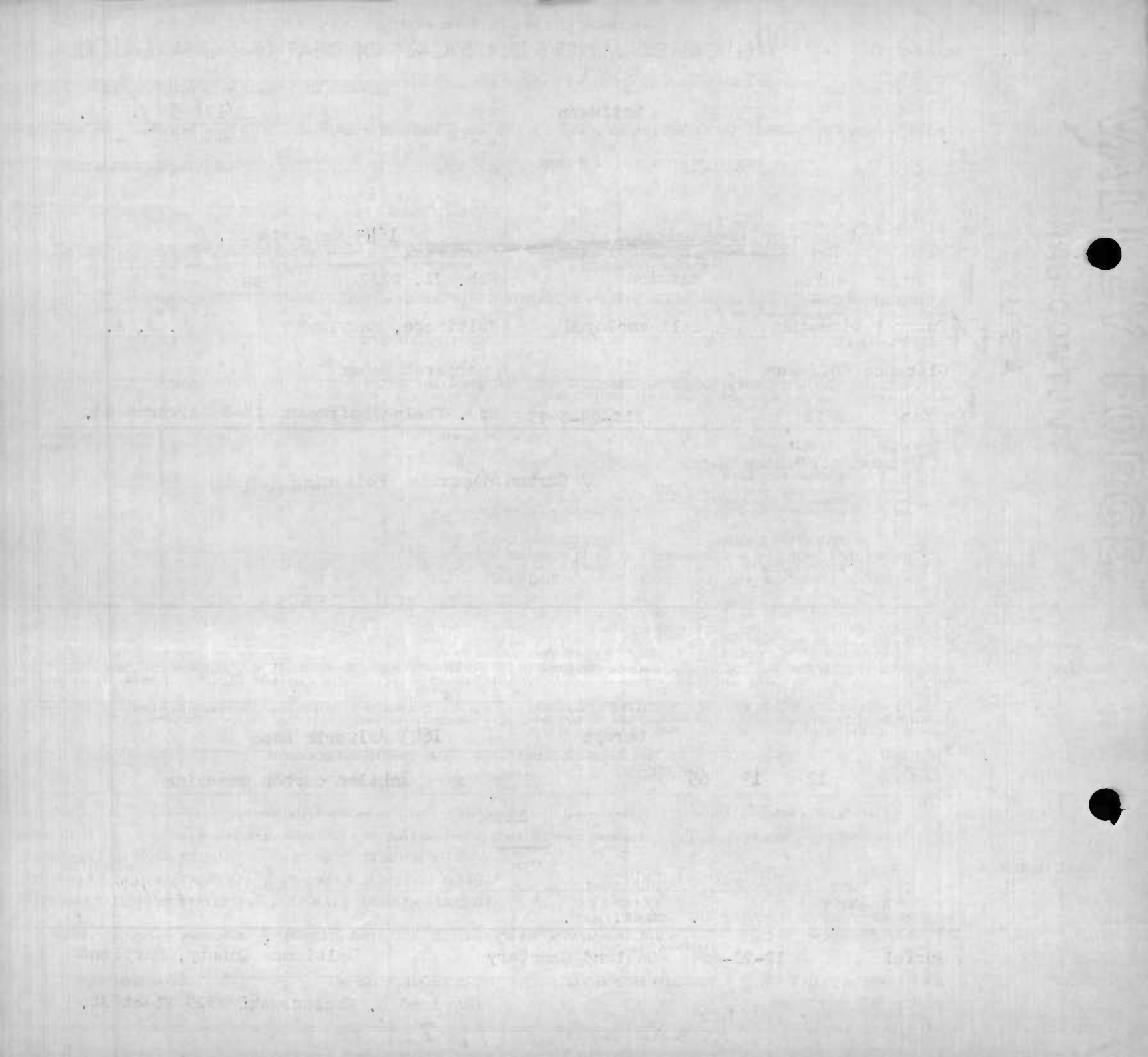
DEC 27 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

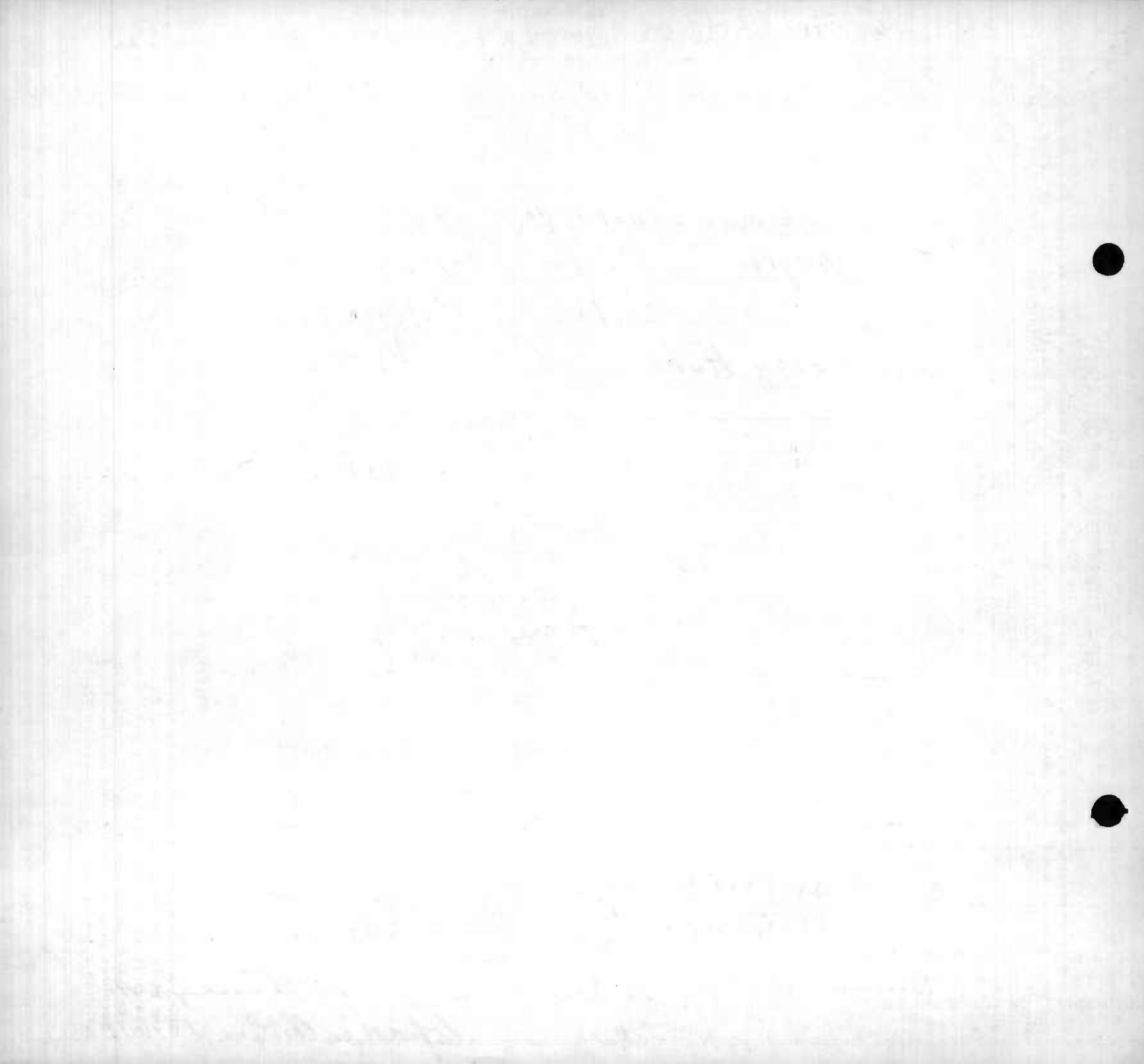
Raymond L. Kaczorowski 2525 Fleet St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 64-0630865 13101 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13101 | |
|---|-------------------------|--|-----------------------------------|---|----------------------------|---|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Rana L. Harris</i> | | | | 2. DATE AND HOUR OF DEATH <i>12-22-65 12:45 PM</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2301</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>147 W. Cross St.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>3-1-63</i> | 9. AGE (In years last birthday) <i>2</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Child</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Leroy Harris</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Lrene Peterson</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <i>491X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Broncho Pneumonia</i> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Anemia</i> | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>0</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that the (this hospital) attended the deceased from <i>12-22</i> 19 <i>65</i> to <i>12-22</i> 19 <i>65</i> , that we (we) last saw the deceased alive on <i>12-22</i> 19 <i>65</i> and that my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>M. Behrman</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-22-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>M. BEHRMAN</i> | | | | 23D. ADDRESS M.D. <i>South Baltimore General</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-27-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>P. J. Jones</i> | | 25C. FUNERAL DIRECTOR <i>Charles A. Rice</i> | | ADDRESS <i>661 W. Barre St</i> | |



FUNERAL DIRECTOR: IMPORTANT

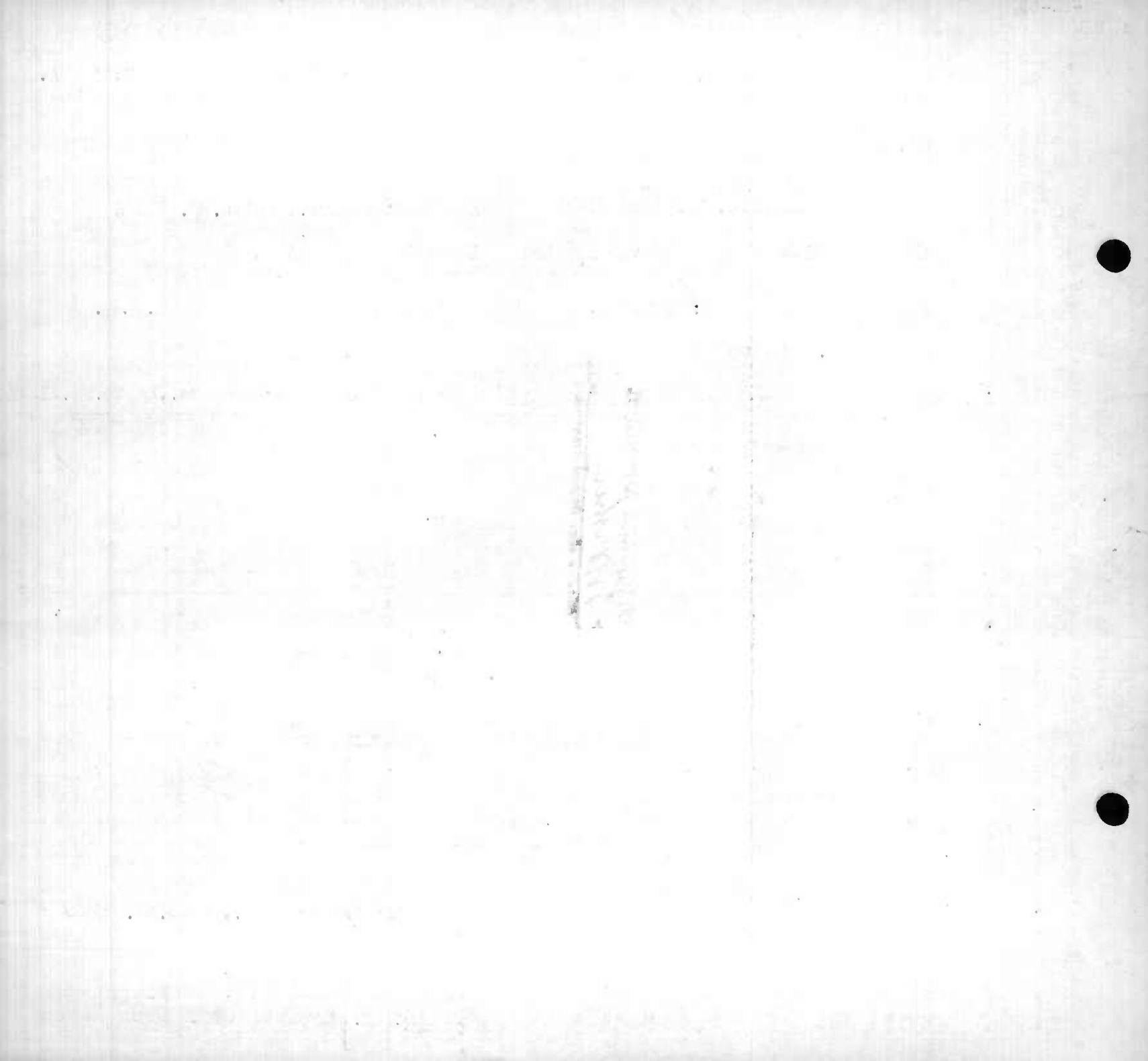
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 65 13102 | | | | | | Registered No. | | 65 13102 | | | |
| 1. NAME OF DECEASED (Type or Print) Lillian P. Bryant | | | | | | 2. DATE AND HOUR OF DEATH December 18, 1965 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) City Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3 Nacelle Rd. | | | | | |
| 5. SEX female | | 6. RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH Oct. 21, 1897 | | 9. AGE (In years, lost birthday) 68 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unknown | | | | | | 14. MOTHER'S MAIDEN NAME unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Wilbert Bryant | | | |
| | | | | | | | | ADDRESS 3 Nacelle Rd. | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | | | | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Hypertensive ASCVD DUE TO Information from medical examiner's office released by medical examiner | | | | INTERVAL BETWEEN ONSET AND DEATH Hours Years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. None | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 19, 1964 to August 4, 1965 , that (I) (we) last saw the deceased alive on Dec 18, 1965 and that In (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Herman Brecher | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/22/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Herman Brecher | | | | | | 23D. ADDRESS 443 E. 25th St. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/65 | | 24C. NAME of CEMETERY or CREMATORY Moreland Memorial | | | | 24D. LOCATION (City, town, or county) (State) Baltimore County Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Dr. A. J. ... | | | | 25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Road #12 | | | | | |

22-84-65
NW
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

| | | | | | |
|---|------------------|--|------------------------------|---|--|
| BIRTH NO. 65 13103 | | BALTIMORE CITY HEALTH DEPT. | | Registered No. 65 13103 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | DICKEY, George | | 2. DATE AND HOUR OF DEATH 12/18/65 7:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | 26-12 | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave., Balto. Md. 21224 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married | 8. DATE OF BIRTH 12/21/80 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton | | 10B. KIND OF BUSINESS OR INDUSTRY Church | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Wyncoop W. Dickey | | 14. MOTHER'S MAIDEN NAME Nettie Gardner | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 2 1 3316 | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH Severe 2nd & 3rd degree burns | | INTERVAL BETWEEN ONSET AND DEATH approx. 1 hr. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Baltimore City Hospital | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City Hospital | |
| 21D. TIME OF INJURY (APPROX.) 12 17 15 8pm | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Patient was found in flames in room 26-12 | |
| 22. I certify that (I) (this hospital) attended the deceased from 10:30 12/17 19 65 to 7:15 12/18 19 65, that (I) (we) last saw the deceased alive on 12/18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Stuart Weeks | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) R. Stuart Weeks | | 23D. ADDRESS M.D. Balt. City Hospital 4940 Eastern Ave., Balto. Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR William E. Johnson | |
| 25C. FUNERAL DIRECTOR 8521 Loch Raven | | 25D. ADDRESS | | | |

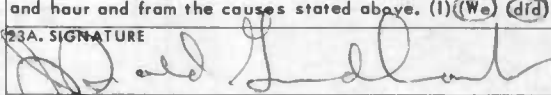


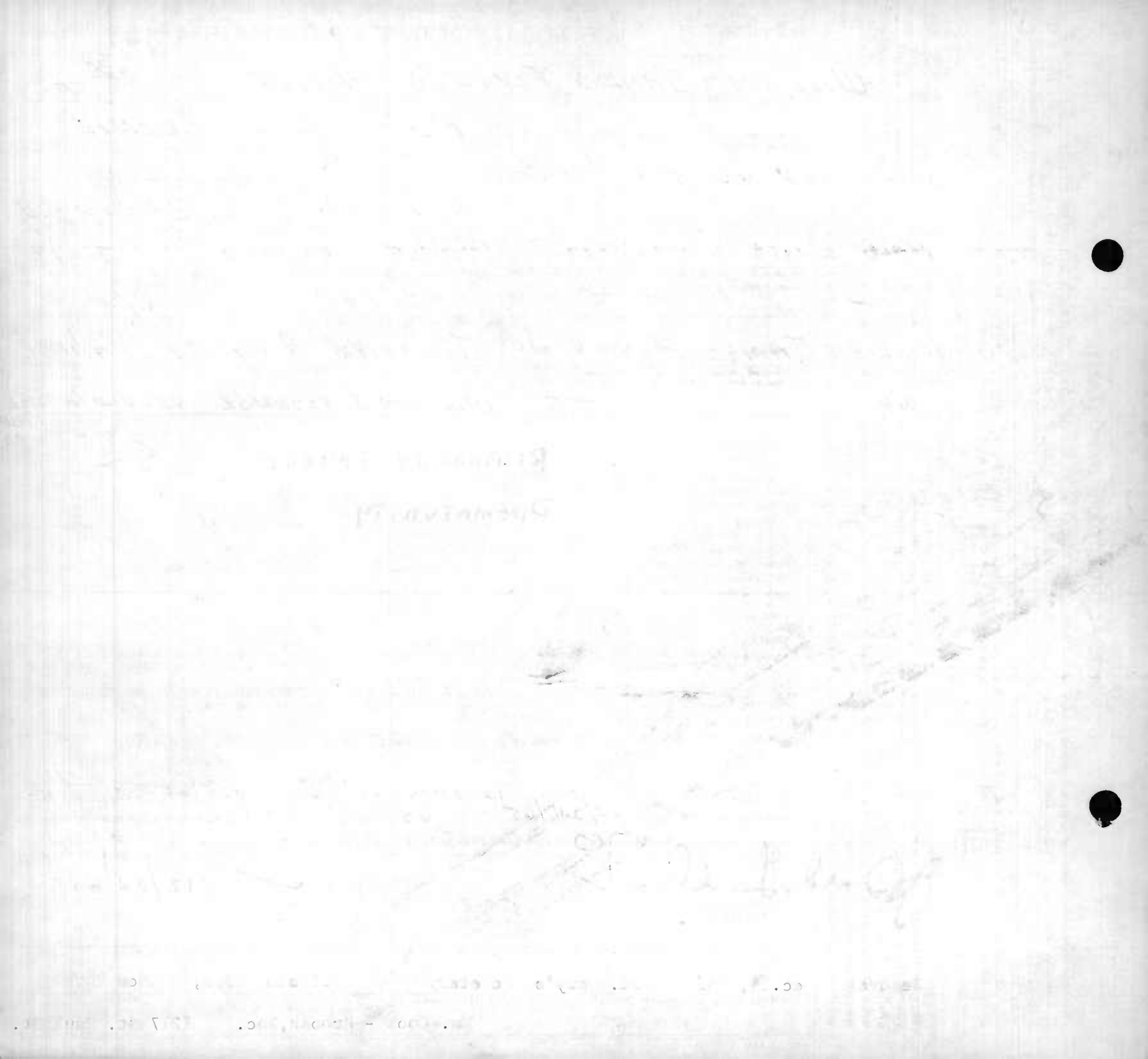
M 2161
Approved & Body Released by Medical Examiner
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|--|-----------------------------|--|--|
| BIRTH NO. 65 13104 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13104 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) McPHERSON C PARKER | | 2. DATE AND HOUR OF DEATH 12-23-1965 11:40 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL BALTIMORE, 18 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Cambridge ARMS APTS. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9-30-76 | 9. AGE (In years lost birthday) 89 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOHN W. McPHERSON | | 14. MOTHER'S MAIDEN NAME ANNIE P. PARKER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or service) | | 16. SOCIAL SECURITY NO. M.D. | | 17. INFORMANT MRS. McPHERSON | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mere existence of heart failure, asthenia, etc. It means the cause, injury or complication which caused death) E9020 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic Cardiovascular disease | | CAUSE OF DEATH (A) DUE TO FRACTURE RT HIP (B) DUE TO Arteriosclerotic Cardiovascular disease (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS WHICH PRECIPITATED OR RISE TO THE ABOVE CAUSE OF DEATH UNDERLYING CONDITION II OTHER SIGNIFICANT CONDITIONS OCCURRING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING DEATH Fracture Right Femur | | | | | |
| 19A. DATE OF OPERATION 12-21-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE RT Hip | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) YES | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) HOME | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec. 19 65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell from bed | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-20-65 19 to 12-23-1965, that (I) (we) last saw the deceased alive on 12-23-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Y.S. MURTHY | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) Y. S. MURTHY | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY OR CREMATORY LORRAINE | |
| 24D. LOCATION WOODLAWN, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | |
| 25B. NAME OF REGISTRAR JOHN D. MITCHELL & SONS - WIEDEFELD | | 25C. FUNERAL DIRECTOR ADDRESS 4500 YORK RD. BALTO. MD. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|--|-------------------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13105 | |
| BIRTH NO. 65 31859 65 13105 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM JAMES FLYNN JR | | 2. DATE AND HOUR OF DEATH 12/24/65 8³⁰ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL | | A. STATE MD B. COUNTY GLEN BURNIE | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 52-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 456 OLD QUARTERFIELD RD. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 12/24/65 | 9. AGE (In years last birthday) New Born | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 2 18 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WILLIAM JAMES FLYNN SR. | | 14. MOTHER'S MAIDEN NAME JOHANNA AUGUSTA YAHNER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT WILLIAM J. FLYNN SR. ADDRESS 456 OLD QUARTERFIELD RD. | |
| 18. 773.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PREMATURITY | | CAUSE OF DEATH (A) RESPIRATORY FAILURE DUE TO (B) PREMATURITY DUE TO (C) _____ | | INTERVAL BETWEEN FIELD ONSET AND DEATH 5 m | |
| MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-24-65 @ 6:12 a.m. to 12/24/65 @ 8:30 a.m. that (I) (we) last saw the deceased alive on 12/24/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Cook | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE Dec. 24, 1965 | | 24C. NAME of CEMETERY or CREMATORY St. Mary's Cemetery | |
| 24D. LOCATION Ballston Spa, New York | | 24E. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | |
| 24F. NAME OF REGISTRAR Robert E. Taylor | | 24G. FUNERAL DIRECTOR ADDRESS Wm. Cook - Brooks, Inc. 1217 St. Paul St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13106 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13106 | |
|---|---------------------|---|-----------------------------------|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) PERKINS, LINA CHRISTIAN | | | | 2. DATE AND HOUR OF DEATH 12/24/65 10:32 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 12-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION M. HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2719 ST. PAUL ST. | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 5/9/90 | | 9. AGE (In years lost birthday) 75 | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY ? | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILLIAM HENRY PERKINS | | | | 14. MOTHER'S MAIDEN NAME MARTHA ELIZ RICHARDSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 212-01-4882 | | 17. INFORMANT ADDRESS Easton Md. | |
| | | | | Carter R. Perkins | | 510 S. Aurora St. | |
| 18. IX DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) ① Carcinoma of the stomach, with liver metastasis, w/ obstruction (B) ② Extension to pancreas (C) ③ Peritonitis, diffuse | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 12/8/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ADDOWEN | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/5/65 to 12/24/65 , that (I) (we) last saw the deceased alive on 12/24/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE VICTOR M. RODRIGUEZ | | | | 23B. DATE SIGNED 12/24/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) VICTOR M. RODRIGUEZ | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 27, 65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR P. A. 2, 76, 05, 00 | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. | | ADDRESS 1217 St. Paul St. | |

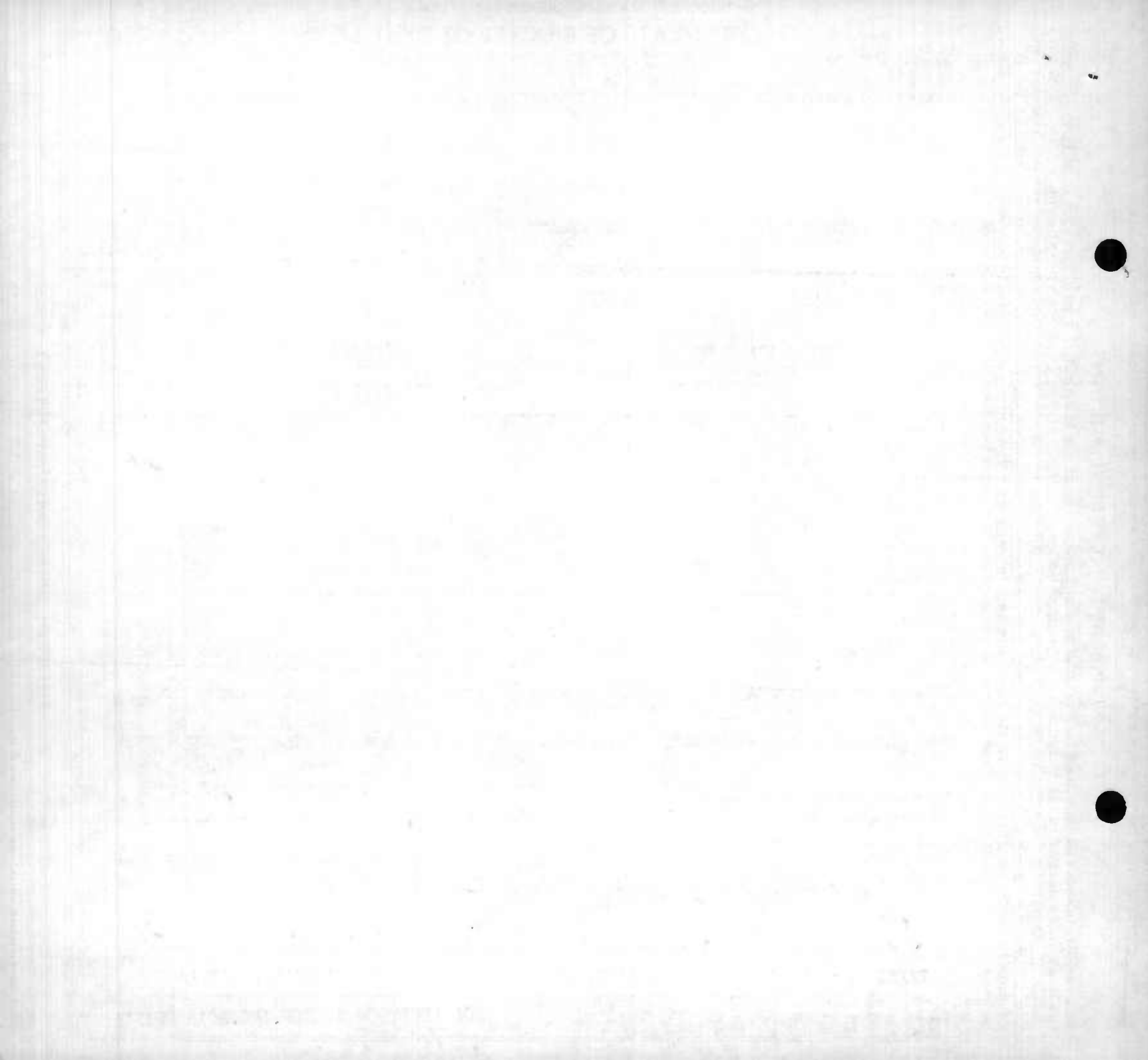
1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

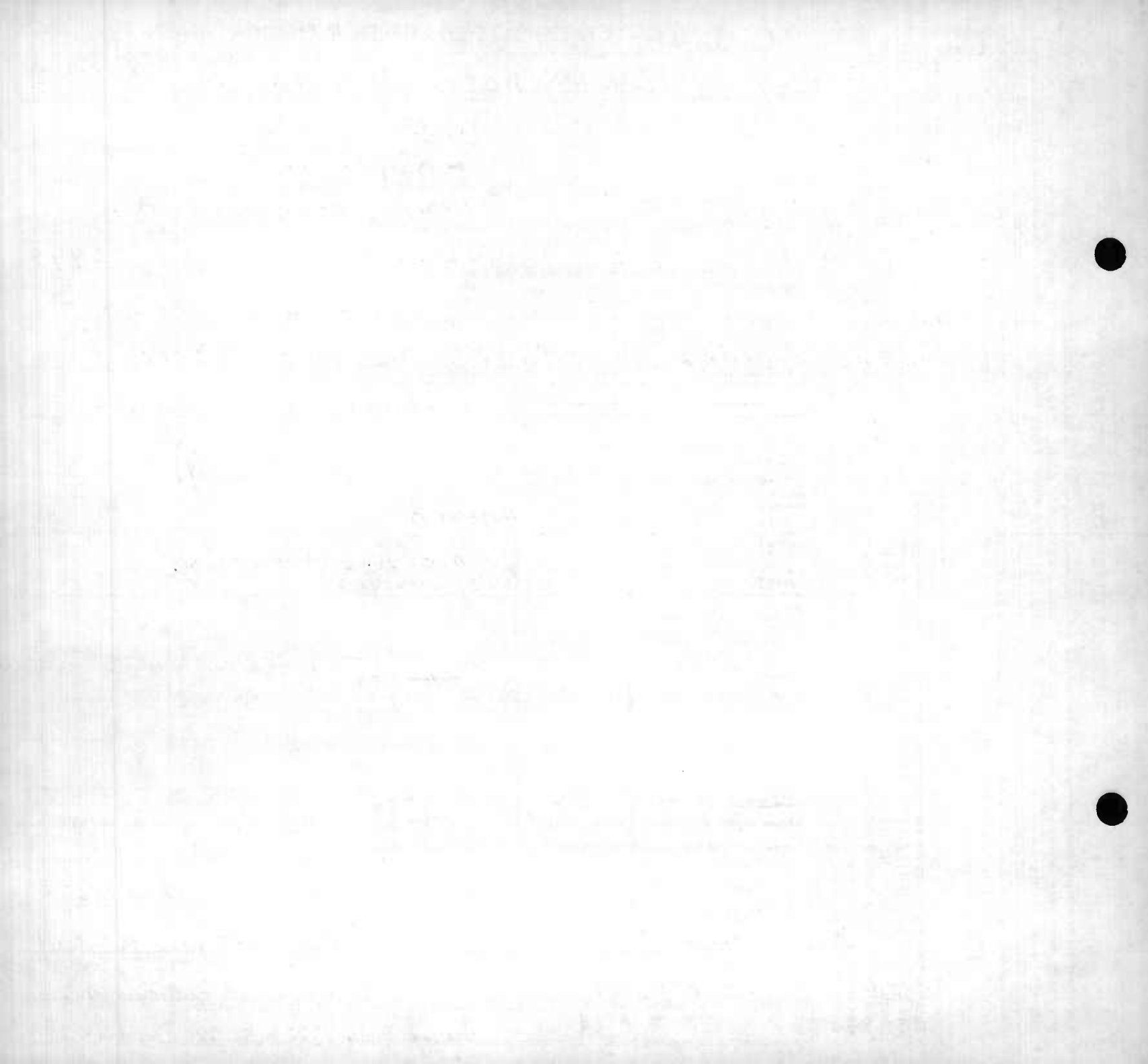
| BIRTH NO. 65 13107 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13107 | |
|--|----------------------|---|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Isaac Adleberg</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/22/1965 8²⁰ A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | If not in hospital or institution, give street address or location | | A. STATE <i>Maryland</i> | | B. COUNTY <i>27-20</i> | |
| <i>Smair Hosp Baltimore</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>7236 Park Heights</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>April 4, 1889</i> | | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WHOLESALE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>POULTRY</i> | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>ABRAHAM ADLEBERG</i> | | | | 14. MOTHER'S MAIDEN NAME <i>RACHAEL ?</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT <i>MRS. ETTA ADLEBERG</i> | | ADDRESS <i>7236 PARK HEIGHTS AVE</i> | |
| 18. <i>420.14-260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Cornary artery disease</i> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes mellitus</i> | | | | | | <i>18 months</i> | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i> | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i> | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>-</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>-</i> | | | |
| 22. I certify that (I) (this, hospital) attended the deceased from <i>1947</i> to <i>Dec 22 1965</i> , that (I) (we) last saw the deceased alive on <i>8 AM 6-5</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Joseph B Gross</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>Joseph B Gross</i> | | | | 23D. ADDRESS <i>6911 Paul Heights Rd.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12/23/65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>SHAAREI ZION</i> | | 24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MARYLAND</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. INC.</i> | | ADDRESS <i>6010 REISTERSTOWN RD</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

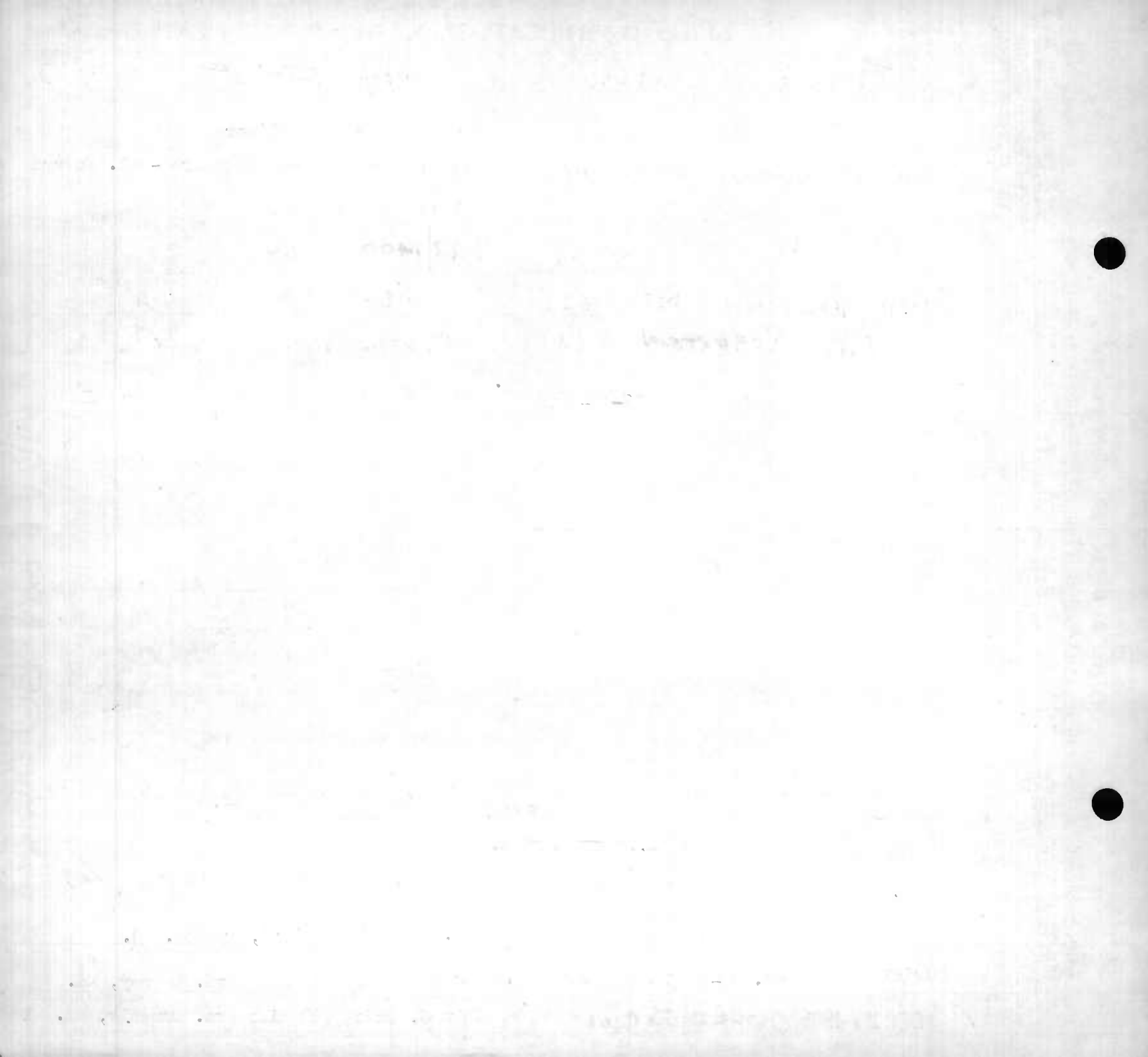
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. <u>65-31511</u> | | <u>65 13108</u> | | <u>65 13108</u> | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>GARY ALLEN Schoen</u> | | | 2. DATE AND HOUR OF DEATH <u>DEC 22, 1965 11 45 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Md. Gen. Hosp.</u> | | | A. STATE <u>md.</u> B. COUNTY <u>Balto.</u> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO #19</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>1341 Beechwood Rd.</u> | | |
| 5. SEX <u>male</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>N.B.</u> | 8. DATE OF BIRTH <u>DEC 22, 1965</u> | 9. AGE (In years lost birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Joseph Edward Schoen</u> | | | 14. MOTHER'S MAIDEN NAME <u>Phyllis Rita Cook</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u> | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Mother</u> |
| 18. <u>762.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Prematurity (Immaturity)</u> DUE TO (B) <u>Anoxia</u> DUE TO (C) <u>Subarachnoid hemorrhage due to anoxia</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>DEC 22 19 65</u> to <u>DEC 22 19 65</u> , that (I) (we) last saw the deceased alive on <u>DEC 22 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>John V. Conway</u> | | | | 23B. DATE SIGNED <u>12/22/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>John V. Conway</u> | | | | 23D. ADDRESS <u>Md. Gen. Hospital, Baltimore Maryland</u> | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>Dec-23-1965</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Garden of Faith</u> | |
| 24D. LOCATION <u>Trumps Mills Rd. Baltimore Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>R. E. J. ...</u> | | 25C. FUNERAL DIRECTOR <u>John H. Duden</u> | | | |
| 25D. ADDRESS <u>7922 Wise Ave Dundalk K 22 Md.</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

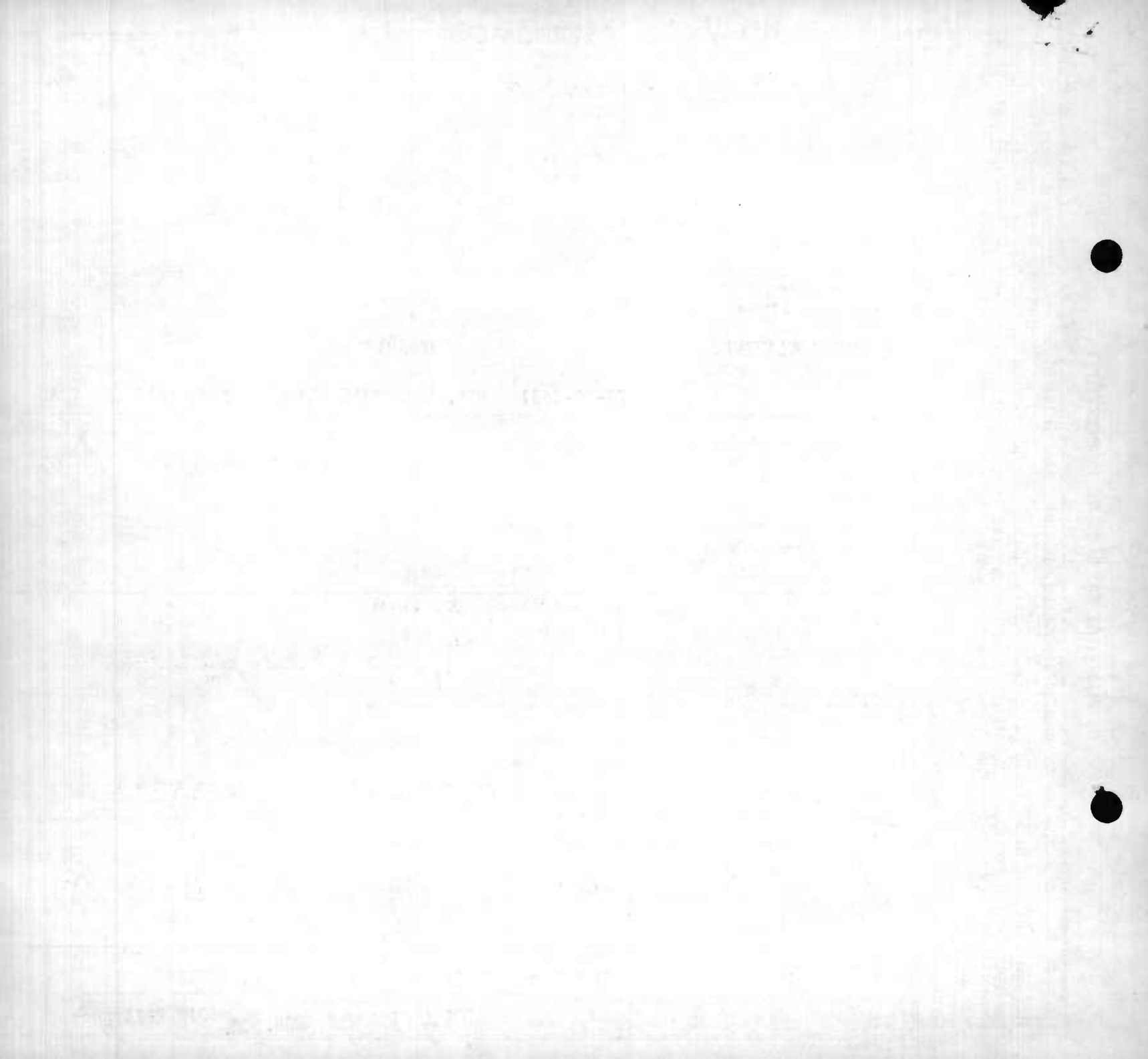
| Baltimore City Health Department | | | | Registered No. 65 13109 | |
|---|--|--|--|--|--|
| BIRTH NO. 65 13109 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JAMES E. ROBERTSON | | 2. DATE AND HOUR OF DEATH 12/24/65 9:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE -- Edgemere - Ft. Howard | | | |
| | | D. STREET ADDRESS (If rural, give location) 696 SHORE RD 53-00 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9/22/1900 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STEEL WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY BETH STEEL | | 11. BIRTH PLACE (State or foreign country) KENTUCKY | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME ADASE ROBERTSON (A) | | | 14. MOTHER'S MAIDEN NAME MARTHA BONNETTE (A) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 233-12-7872 | | 17. INFORMANT WIFE ADDRESS SAME | |
| 18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Vascular thrombosis (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 15 weeks | | | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 9/18 19 65 to 12/24 19 65 and that (H) (we) lost saw the deceased alive on 12/24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ronald Golden M.D. | | 23B. DATE SIGNED 12/24/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Ronald Golden | | 23D. ADDRESS Md. General Hospital, Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE Dec. 28-1965 | 24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial | | 24D. LOCATION (City, town, or county) (State) Washington Blvd. Dorsey, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | 25B. NAME OF REGISTRAR R. E. Johnson | 25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md. 21222 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

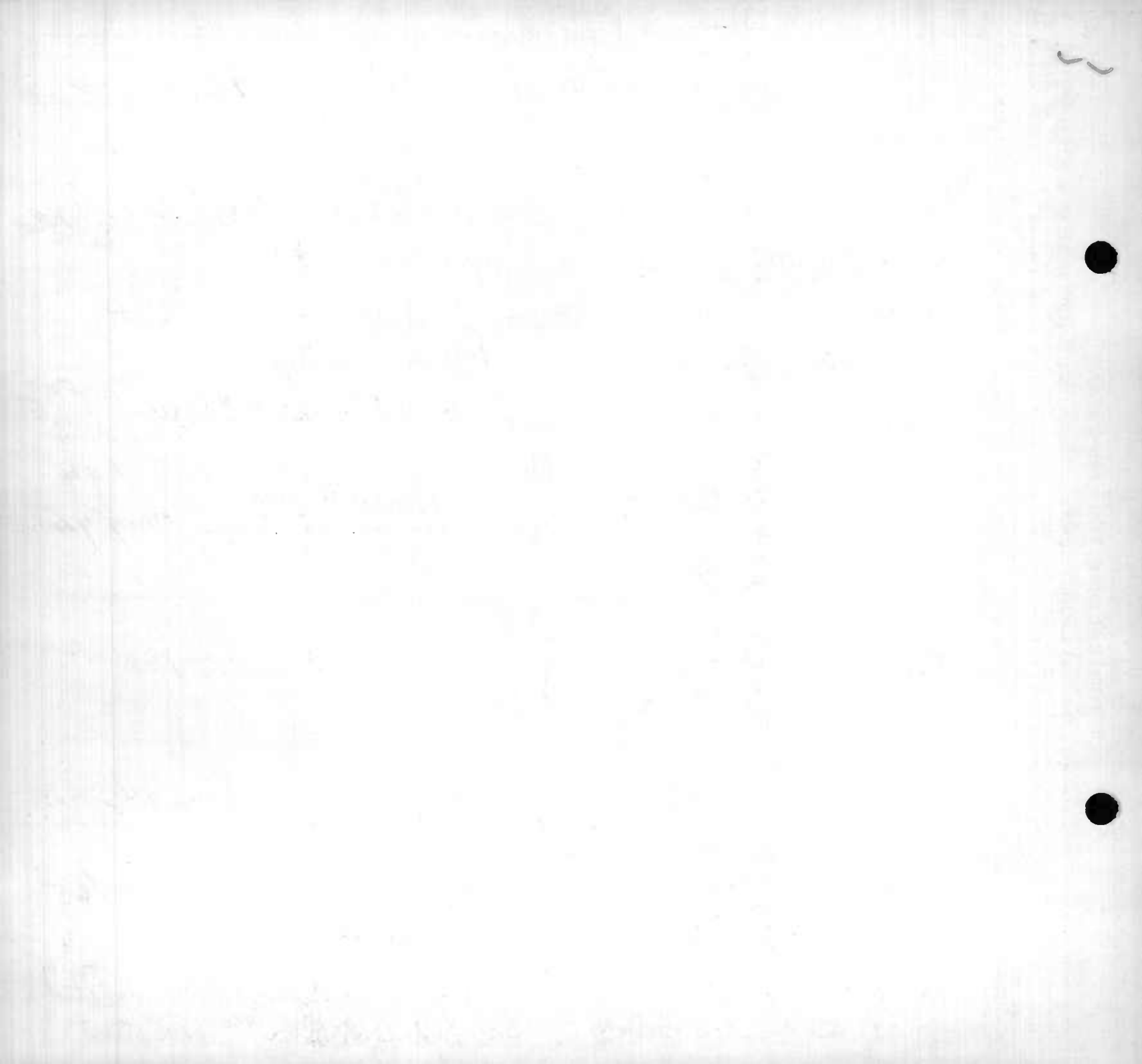
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13110 | |
|--|---|--|--|---|--|
| BIRTH NO. 65 13110 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) KLATZKIN, BENJAMIN | | 2. DATE AND HOUR OF DEATH 12-23-65 10 ¹⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY BALTO. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL of BALTO. BALTO. 15, MD | | D. STREET ADDRESS (If rural, give location) LEVINDALE HOME | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11/25/1888 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDMADE SHOE | | 10B. KIND OF BUSINESS OR INDUSTRY RETAIL | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME SAMUEL KLATZKIN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 577-09-8631 | | 17. INFORMANT ADDRESS MRS. KATHERINE GOLDMAN 3647 LANGREHR ROAD | |
| 18. 420.14-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION 1 day | | CAUSE OF DEATH (A) DUE TO ASCVD | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PULMONARY EDEMA Diabetes Mellitus | | | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-22-65 19 to 12-23-65 19 that (I) (we) last saw the deceased alive on 12-23-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Larry A. Snyder M.D. | | 23B. DATE SIGNED 12-23-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Larry A. Snyder M.D. | | 23D. ADDRESS Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12/24/65 | 24C. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL | 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | 25B. NAME OF REGISTRAR Robert E. Taylor | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. | | ADDRESS 6010 REISTERSTOWN RD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13111 | |
| BIRTH NO. 65 13111 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Barnett Nitzburg | |
| 2. DATE AND HOUR OF DEATH 12/24/65 7:45 AM | | M. 1 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-17 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines Belvedere, W. Belvedere Ave | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| D. STREET ADDRESS (If rural, give location) 2525 W. Belvedere Ave | | 5. SEX Male | |
| 6. RACE White | 7. MARRIED, NEVER MARRIED Married | 8. DATE OF BIRTH April 5, 1884 | 9. AGE (In years last birthday) 81 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 10B. KIND OF BUSINESS OR INDUSTRY Internal Revenue | 11. BIRTHPLACE (State or foreign country) Kansas | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Jacob Nitzburg | | 14. MOTHER'S MAIDEN NAME Kathie Nitzburg | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Park West Memorial Chapel | | ADDRESS ny-ny | |
| 18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of Prostate Gland. | | CAUSE OF DEATH (A) DUE TO Coronary Artery Disease | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs. Many years. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 15 1965 to Dec 24 1965 , that (I) (we) last saw the deceased alive on Dec 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Leonard Kotz | | 23B. DATE SIGNED 12/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) LEONARD KOTZ | | 23D. ADDRESS 11 SLADE AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 12/24/65 | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt Lebanon | | 24D. LOCATION (City, town, or county) Ridgewood, Long Island | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Sal Herman | |
| 25C. FUNERAL DIRECTOR Sal Herman | | ADDRESS 2nd - 6010 Kent Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13112 | |
|--|----------------------|--|---|--|---|
| BIRTH NO. 65 13112 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Lillian R. SAFRANEK | | 2. DATE AND HOUR OF DEATH 12/21/65 11:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hosp. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 734 E. 36th Street | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 7/25/02 | 9. AGE (In years last birthday) 63 yrs | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Harry B. Cook Co | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME Charles H. Knight | | | 14. MOTHER'S MAIDEN NAME Lillian Russell | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-07-9372 | | 17. INFORMANT ADDRESS Albert J. Safranek, husband, above | |
| 18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Septicemia DUE TO (B) Bronchopneumonia DUE TO (C) Asphyxia | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 12/21/65 19 65 to 12/21/65 that (we) last saw the deceased alive on 11:30 PM 12/21/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry J. Brown | | | | 23B. DATE SIGNED 12/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY J. BROWN | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/65 | | 24C. NAME OF CEMETERY OR CREMATORY Bohemian Nat. Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. LOCATION (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR 02-12-12-12 | | 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane | |

9

11th March 1944

11th March 1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13113 | |
|---|-----------------------|---|--|---|---|
| BIRTH NO. 65 13113 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mary A. Ritterpusch | | | 2. DATE AND HOUR OF DEATH 12-20-65 10 ³⁰ P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital 827 Linden Ave 21201 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 13-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2401 Eutaw Place (Lakeside Nurs. Home) | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 5-17-80 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Lanahan? | | | 14. MOTHER'S MAIDEN NAME Unknown? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Bernard W. Ritterpusch 3503 Cliftnont Ave, Hospital Chart | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 827 | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/16 1965 to 12/20 1965, that (I) (we) last saw the deceased alive on 12/20 1965 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John M. Steffy | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/20/65 |
| 23C. PHYSICIAN'S NAME (Type) John M. Steffy | | | 23D. ADDRESS M.D. 827 Linden Ave 21201 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/23/65 | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. J. [Signature] | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane #13 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---|--|---|--|--|
| BIRTH NO. 65 13114 | | CERTIFICATE OF DEATH | | 65 13114 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) (or Mary) Mamie Miller | | 2. DATE AND HOUR OF DEATH 22 Dec 65 12 30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Fayette Nursing Home | | A. STATE Maryland | | B. COUNTY 381 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 269 S Dallas Ct | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 5/23/85 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Christian Martin | | | 14. MOTHER'S MAIDEN NAME Catherine Anton | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Jos Martin (bro) | | ADDRESS 675 4263 2737 Ashland Ave 21205 |
| 18. 491X I | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Bronchopneumonia | | | 5 days |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| | | Cerebral Thrombosis (57) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12 Jan 19 62 to 22 Dec 19 65 , that (I) (we) last saw the deceased alive on 22 Dec 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J Hulla | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 22 Dec 65 | |
| 23C. PHYSICIAN'S NAME (Type) J Hulla | | 23D. ADDRESS M.D. 2214 E Fayette St 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/24/65 | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Schubert Funeral Home, Inc. ADDRESS 2601 E Madison St. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13115 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13115 | |
|--|-------------------------|---|-------------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HANLON, MARGARET M. | | | | 2. DATE AND HOUR OF DEATH December 21, 1965 9 am M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Conv. Home | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3401 Shannon Drive #13 | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH 3/9/1889 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Corsetier | | 10B. KIND OF BUSINESS OR INDUSTRY Blums Dept. Store | | 11. BIRTHPLACE (State or foreign country) Penn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME David H. Hanlon | | | | 14. MOTHER'S MAIDEN NAME Mary Gallagher | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Loretta H. Murray, above, sister | | | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 19 65 to December 21 19 65 , that (I) (we) last saw the deceased alive on December 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Albert B. Bradley | | | | 23D. ADDRESS M.D. 4900 Belair Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/65 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | ADDRESS 3331 Brehms Lane #13 | |

Don't look there
Change direction

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Mr O'Connell

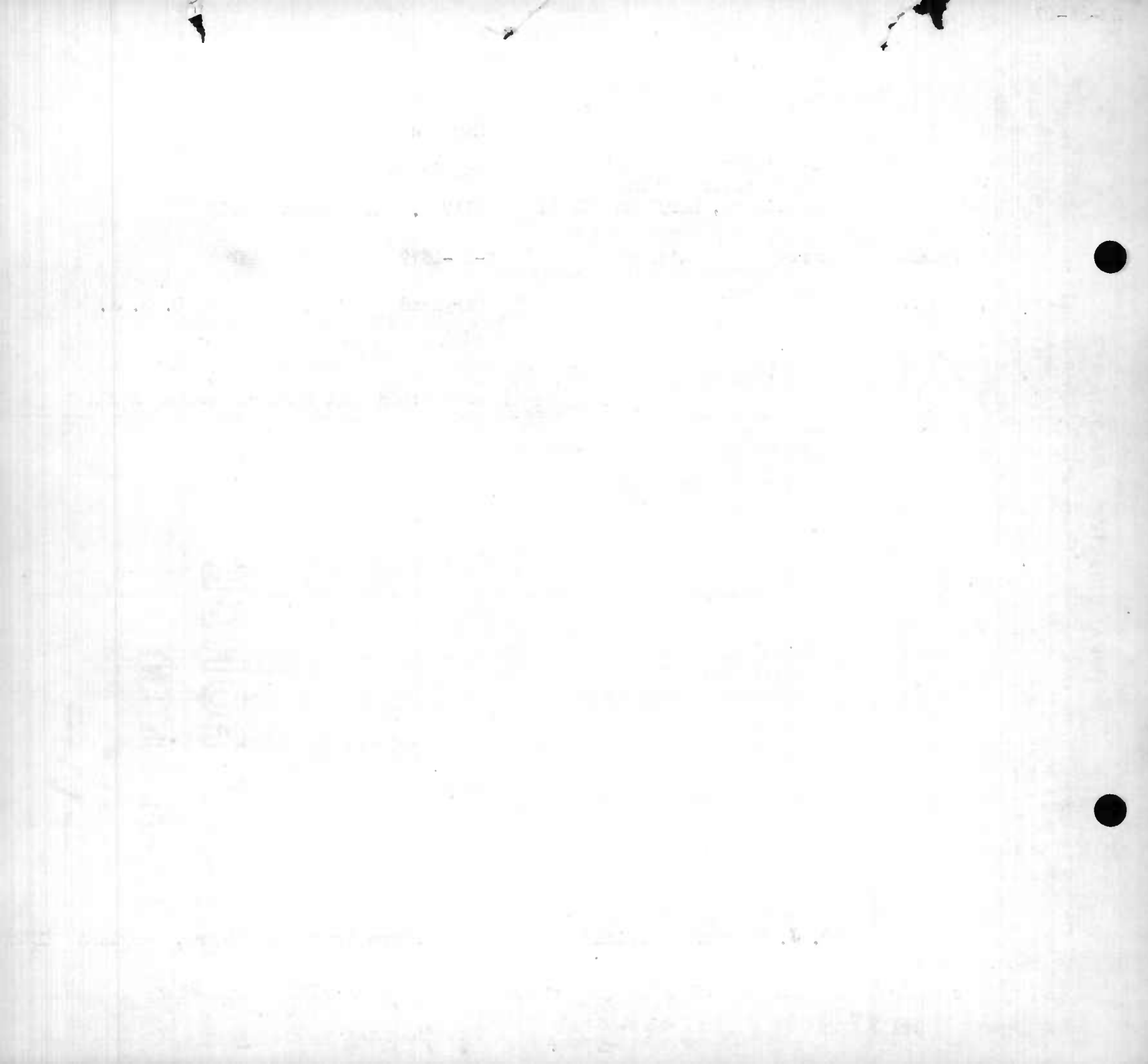
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

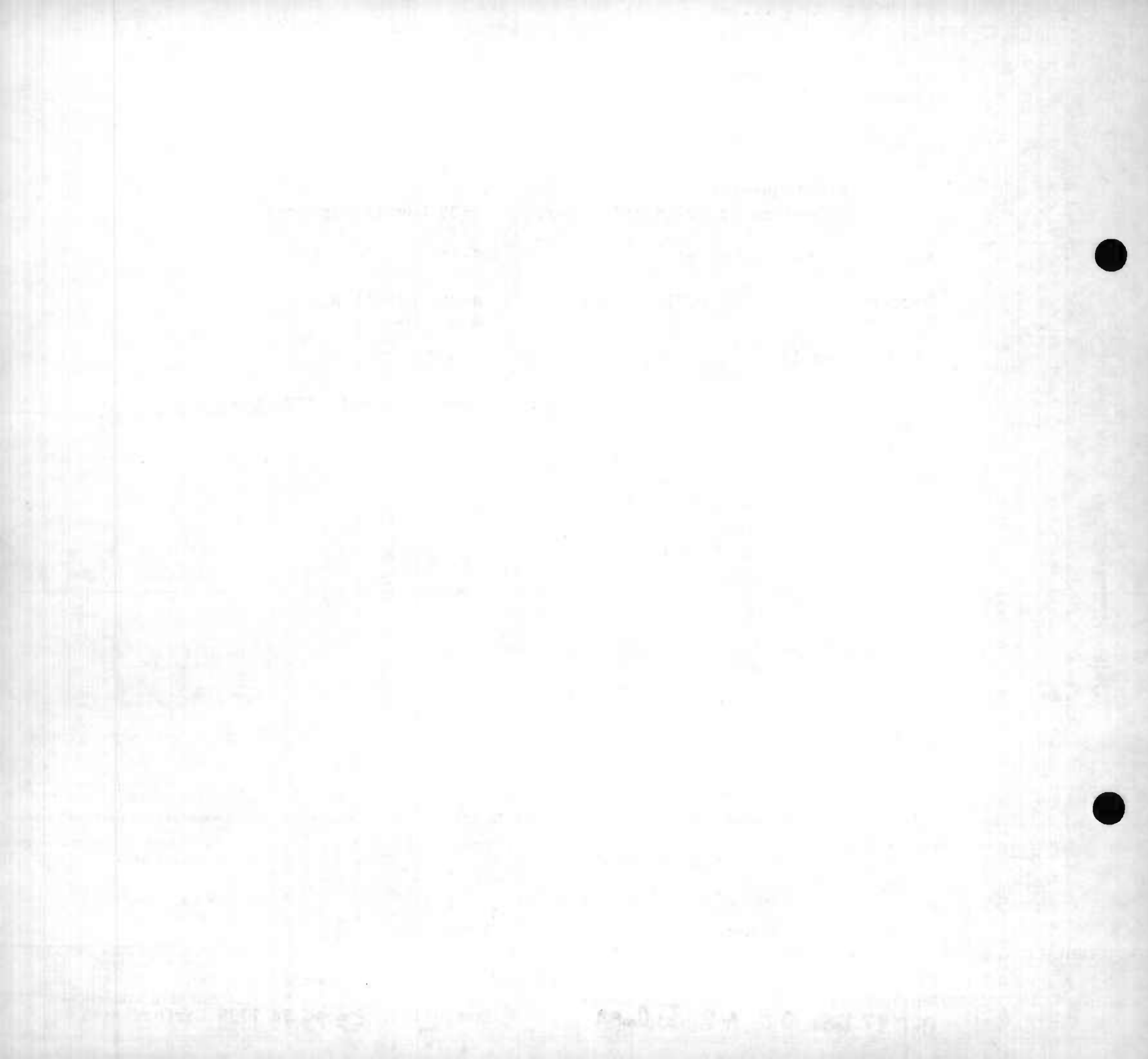
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Baltimore City Health Department | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 536 65 13116 | | | | Registered No. 13116 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MARTHA A. (MATTIE) Pinder | | | 2. DATE AND HOUR OF DEATH 12-22-65 4:00 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-80 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| D. STREET ADDRESS (If rural, give location) 1117 N. Bond Street 21213 | | | D. STREET ADDRESS | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8-12-1884 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME John James | | |
| 14. MOTHER'S MAIDEN NAME Elizabeth | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 212-36-6279 | | | 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | | |
| 18. CAUSE OF DEATH 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-20-65 19 to 12-22 19 65 , that (I) (we) last saw the deceased alive on 12-22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Patrick Caulfield M.D. | | | 23B. DATE SIGNED 12-22-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. J. Patrick Caulfield M.D. | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12-27-65 | | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery Baltimore, Md. | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | 25B. NAME OF REGISTRAR Robert E. [unclear] | | |
| 25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. | | | 25D. ADDRESS 1735 Harford Ave. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13117 | |
|--|-------------------------|--|-------------------------------------|---|---|
| BIRTH NO. 65 13117 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Jeremiah Fennell | | 2. DATE AND HOUR OF DEATH 12-23-65 6:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital Belvedere at Greenspring Ave. | | A. STATE Md. | | B. COUNTY 15-13 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2533 Loyola Northway | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED Married | 8. DATE OF BIRTH 8-5-1896 | 9. AGE (In years lost birthday) 69 | If Under 1 Yr. Months Days Hours Min. USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Portor | | 10B. KIND OF BUSINESS OR INDUSTRY Office Bldg. | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Andrew Fennell | | 14. MOTHER'S MAIDEN NAME Mary ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1 | | 16. SOCIAL SECURITY NO. 218-03-8412 | | 17. INFORMANT Mary E. Fennell-2533 Loyola Northway | |
| 18. 456X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE | | CAUSE OF DEATH (A) DUE TO CONGESTIVE HEART FAILURE | | INTERVAL BETWEEN ONSET AND DEATH Several months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO AORTITIS | | Several months | |
| | | (C) DUE TO Unk. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 65 to 12-23 19 65 , that (I) (we) last saw the deceased alive on Dec. 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lucius W. Leeper | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec. 24, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Lucius W. Leeper | | 23D. ADDRESS 1200 Bloomington Rd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-28-65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Marshall W. Jones, Jr | |
| | | | | ADDRESS 1735 Harford Ave. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

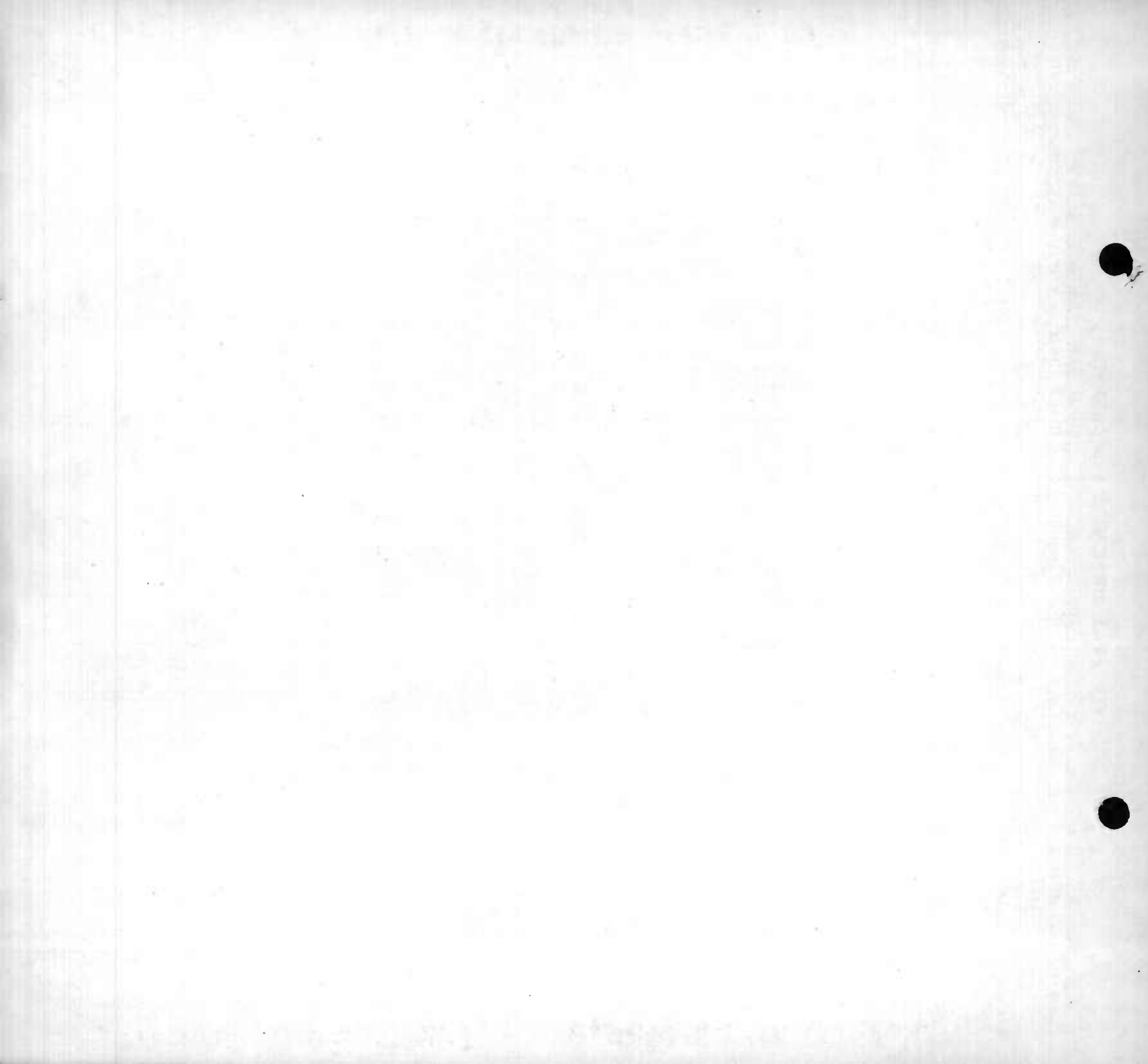
VS 150-REV. 1/1/65

vs 153 signed by funeral director.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13119 | |
|---|---------------------|--|--|--|--|
| BIRTH NO. 65 13119 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED RAYMOND KELCH | | 2. DATE AND HOUR OF DEATH DEC. 24 1965 8:05 A.M. | |
| 1. NAME OF DECEASED (Type or Print) | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hosp. | | A. STATE MD B. COUNTY Baltimore City | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | | | |
| D. STREET ADDRESS (If rural, give location) 1336 Hollins St. | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH Aug. 10, 1910 | 9. AGE (in years lost birthday) 55 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TUBE INSPECTOR | | 10B. KIND OF BUSINESS OR INDUSTRY Revere Co | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Nellie Kelch - Above | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema | | CAUSE OF DEATH (A) DUE TO Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 3 Hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1965 to Dec. 24 1965 , that (I) (we) last saw the deceased alive on Dec. 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) BENIGNO M. OTEYZA | | 23D. ADDRESS 415 GILMORE RD. UPPA, MD. 21085 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Funeral | | 24B. DATE 12/28/65 | | 24C. NAME OF CEMETERY or CREMATORY Western Cem. | |
| 24D. LOCATION Balto | | 24E. LOCATION (City, town, or county) (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR John J. Caran + Son | | 25C. FUNERAL DIRECTOR Balto | |
| 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. <u>65-3021065 13120</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 13120</u> | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Baby Girl Conley</u> | | | 2. DATE AND HOUR OF DEATH <u>12-21-65</u> <u>4:35 P.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>24-03</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hosp.</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>21230</u> | | |
| 5. SEX <u>F.</u> | | | 6. RACE <u>W.</u> | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEW BORN</u> | | | 8. DATE OF BIRTH <u>12-5-65</u> | | |
| 9. AGE (In years last birthday) <u>N.B.</u> | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Wm. Grayson Conley</u> | | | 14. MOTHER'S MAIDEN NAME <u>Sharon Higginbotham</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>1308 William St.</u> | | |
| 17. INFORMANT <u>Wm. G. Conley</u> | | | 18. <u>289.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) <u>MeConium ileus</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>12/7-65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>intestinal obstruction</u> | | 20A. AUTOPSY? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that at (this hospital) attended the deceased from <u>12-8</u> 19 <u>65</u> to <u>12-21</u> 19 <u>65</u> , that we (we) last saw the deceased alive on <u>12-21</u> 19 <u>65</u> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>M. Behrooz</u> | | | 23B. DATE SIGNED <u>12-22-65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>M. BEHROOZ, M.D.</u> | | | 23D. ADDRESS <u>South Balto. Gen. Hosp. - 1213 Light St.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-22-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, A.A. Co. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>McGully</u> | | 25D. ADDRESS <u>130 E. Fort Ave</u> | |

McCombs

Presenting

Presenting

M. B. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 13121 | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| BIRTH NO. 65 13121 | | CERTIFICATE OF DEATH | | | | | | Registered No. 65 13121 | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>BERTHA H. MARSHALL</i> | | | | | | 2. DATE AND HOUR OF DEATH <i>12-22-65</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>AA.</i> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>S.B.C.N.</i> | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BROOKLYN PK. 52-00</i> | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) <i>222 Dixie Ave</i> | | | | | |
| 5. SEX <i>F</i> | | 6. RACE <i>white</i> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i> | | 8. DATE OF BIRTH <i>Feb 19, 1909</i> | | 9. AGE (In years last birthday) <i>56</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MD</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Chris Roday</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>✓</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Family</i> | | | | ADDRESS <i>Same</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.11</i> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | CAUSE OF DEATH (A) <i>coronary arteriosclerosis</i> DUE TO (B) <i>coronary insufficiency</i> DUE TO (C) | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>○</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>October 1963</i> to <i>12-21-1965</i> , that (I) (we) last saw the deceased alive on <i>12-16-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>E. Schnitzer</i> | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12-22-65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>EUGENE SCHNITZER</i> | | | | | | 23D. ADDRESS M.D. <i>3904 S. Hanover St. Balt. 25, Md.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-24-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill</i> | | | | 24D. LOCATION (City, town, or county) (State) <i>Brooklyn 25, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | | | 25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i> | | | | 25C. FUNERAL DIRECTOR <i>McGlynn Funeral Home</i> | | | |

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BIRTH NO. 65 13122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13122
M.E. CASE NO.

| | | | | | |
|---|------------------|---|--|---|---|
| 1. NAME OF DECEASED (Type or Print) | | ELLA NEWELL | | 2. DATE AND HOUR PRONOUNCED DEAD December 22, 1965 8:04 2:05 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1102 Bradford Street | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH May 22, 1899 | 9. AGE (In years last birthday) 66 | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Warrenton, N. C. | |
| 13. FATHER'S NAME Frank Taylor | | | 14. MOTHER'S MAIDEN NAME Lelia (MN Unknown) | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Herman Robinson - 1102 Bradford St. Balto., Md. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and Arteriosclerotic Cardiovascular Disease. INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Anoxia secondary to laryngeal obstruction secondary to operative intubation and carcinoma of thyroid. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/23/65 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/26/65 | | 23C. NAME of CEMETERY or CREMATORY Mt. Pigsha Baptist Cemetery | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 24B. NAME OF REGISTRAR O. L. G. E. J. J. J. | | 24C. FUNERAL DIRECTOR ADDRESS Green Funeral Home - Warrenton, N. C. | |

VALLEY FORGE

THE CONVENT

22/1/82

BIRTH NO.

65 13123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13123

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EVERETT C. LOVELESS

2. DATE AND HOUR PRONOUNCED DEAD

12/2/65 5:55 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - rural

D. STREET ADDRESS (If rural, give location)

6 Arbutus Dr.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Dec. 31, 1915

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life)

Employed Transit

10B. KIND OF BUSINESS OR INDUSTRY

Public Transit
Company

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Richard Loveless

14. MOTHER'S MAIDEN NAME

XXXXXX Agnes Crook

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

578-12-0883

17. INFORMANT

Everett C. Loveless, Jr. Box 112
Owings, Md.

ADDRESS

18.

E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Route 1 - 2 miles south of Elkridge

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 2 65 5:33 p.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/3/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/6/65

23C. NAME of CEMETERY or CREMATORY

Trinity Cemetery

23D. LOCATION

(City, town, or county)

Upper Marlboro

(State)
Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1965

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Ritchie Bros. Upper Marlboro, Md.

ADDRESS

100

2191-13-30

SIR 1982

2000-2001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

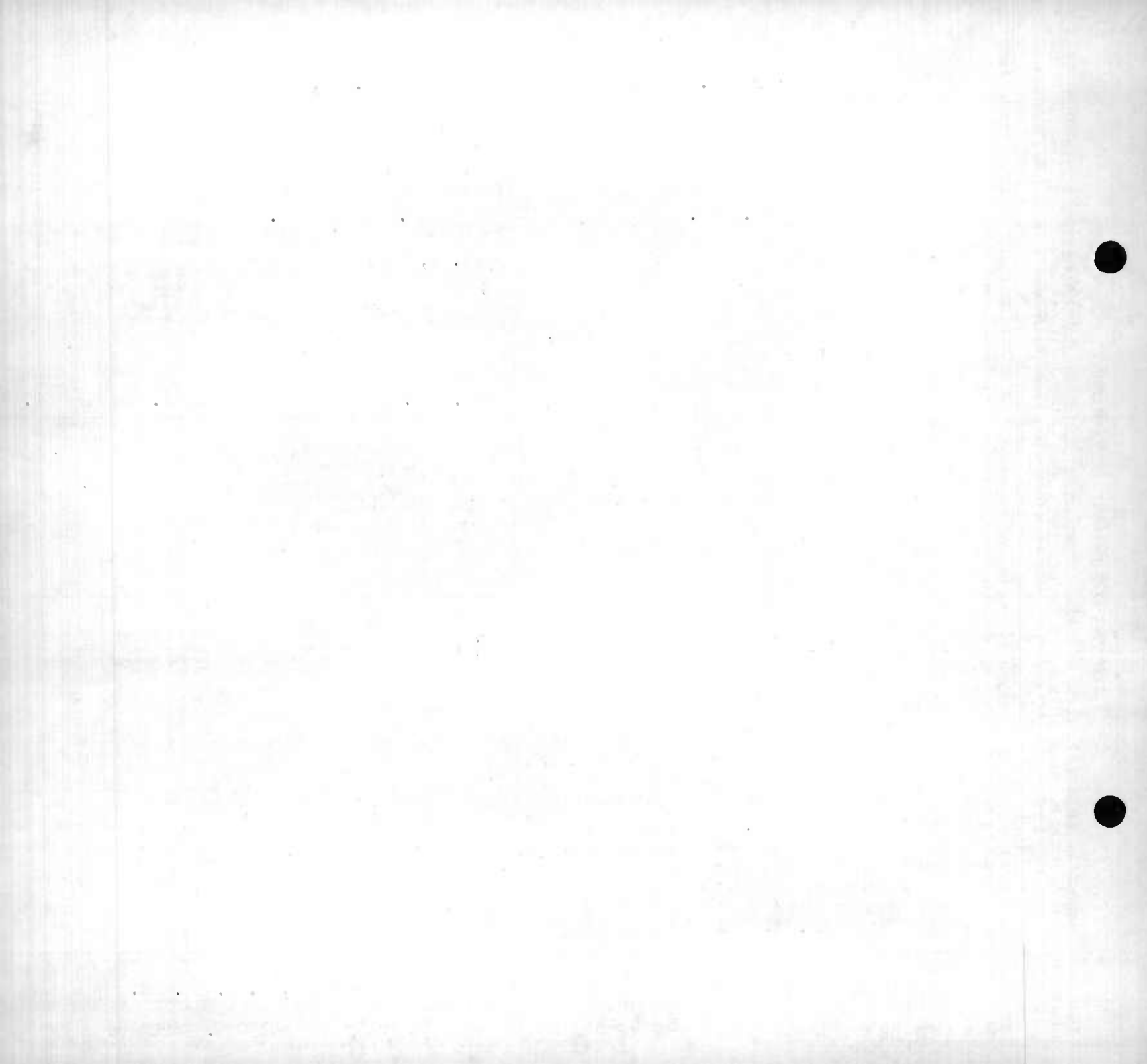
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|------------------------------------|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|
| BIRTH NO. 65 13124 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 13124 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) FRANK WEST | | | | | 2. DATE AND HOUR OF DEATH 12-20-65 11:25 A.M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-05 | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BAR-WIL-Ba 2101-W Cold Spring LA Baltimore Md. 21209 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | | | | | | | | | | |
| D. STREET ADDRESS (If rural, give location) 322 E Lafayette Ave | | | | | | | | | | | | | | | | | | | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | | 8. DATE OF BIRTH 3-10-82 | | 9. AGE (in years last birthday) 83 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME John West | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. 218-01-9700 | | | | | 17. INFORMANT M'sx Sarah Wilson | | | | | ADDRESS 1618 N. Fulton | | | | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis | | | | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) No | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-26-1965 to 12-20-1965 , that (I) (we) last saw the deceased alive on 12-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE CR Campbell | | | | | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED 12-20-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) CR Campbell | | | | | | | | | | M.D. ADDRESS 1618 W. North Ave. Baltimore, Md. | | | | | | | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | | | | 24B. DATE 12-23-65 | | | | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem | | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | | | 25C. FUNERAL DIRECTOR (Mrs) Frances A. Hemsley | | | | | 578 ADDRESS Biddle St. | | | | |

Chapman
Chapman

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

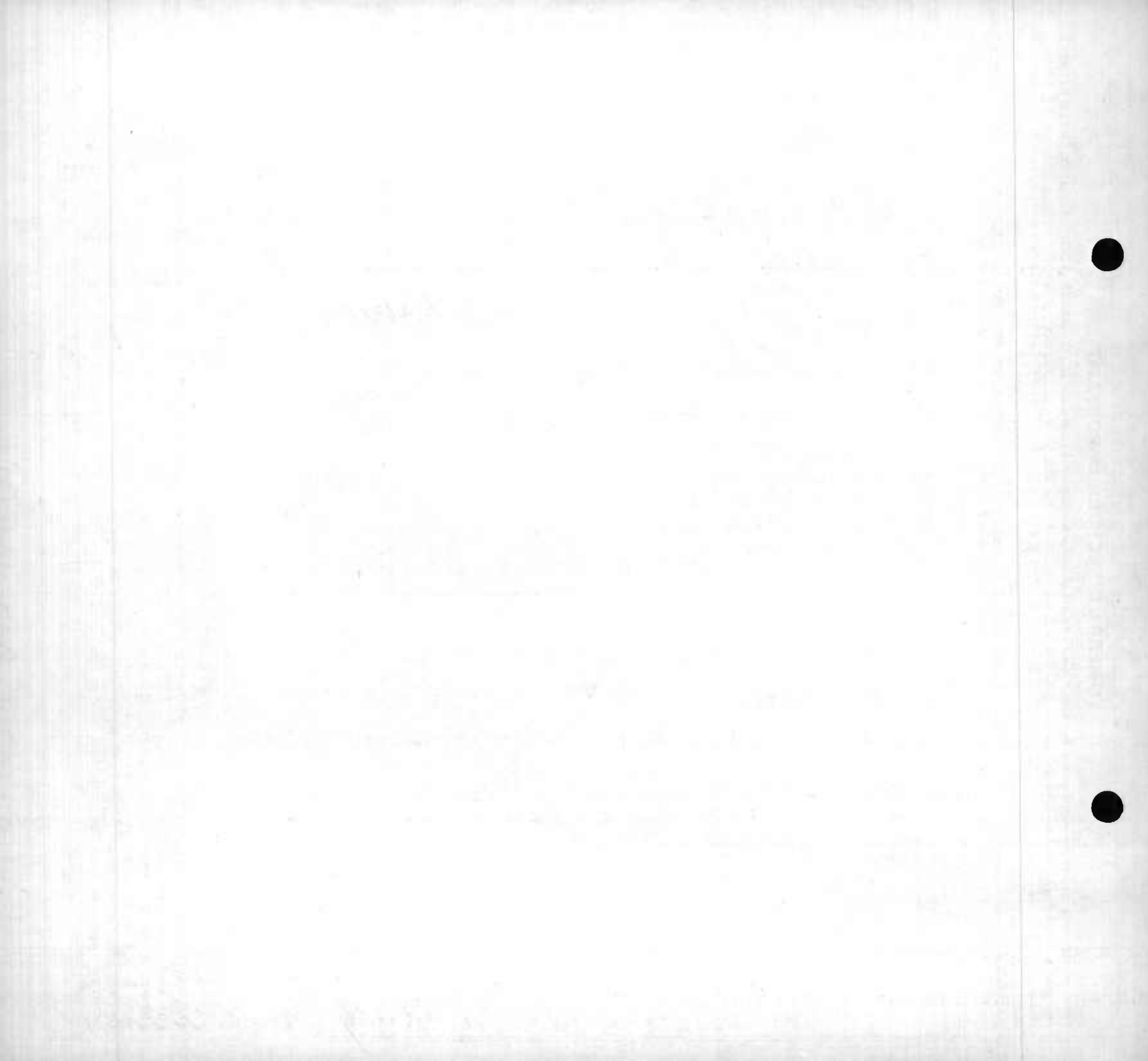
| | | | | | |
|--|-----------------------|---|----------------------------------|--|--|
| BIRTH NO. 65 13125 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13125 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mary E. Bonce | | 2. DATE AND HOUR OF DEATH Dec. 21, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Balto. Gen. Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 23-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1049 S. Charles St. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH Oct. 2, 1897 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME James O'Hara | | 14. MOTHER'S MAIDEN NAME Maryann Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Margaret Johnson | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO Arterio sclerotic Heart Disease (B) DUE TO Generalized arterio sclerosis (C) | | INTERVAL BETWEEN ONSET AND DEATH 2-3 years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/3 1963 to 12/21 1965, that (I) (we) last saw the deceased alive on 12/20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry Deibel | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. H. Deibel | | 23D. ADDRESS M.D. 1526 Hanover St Balto 30 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12 24 65 | 24C. NAME of CEMETERY or CREMATORY Holy Cross | | 24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR R. E. Jones | | 25C. FUNERAL DIRECTOR Mc Cully | |
| | | | | ADDRESS 130 E. Fort Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|---------------------------------|--|------------------------------------|--|
| BIRTH NO. | | 65 13126 | | 65 13126 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Alice Winchester | | | 12-22-65 11:45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| South Baltimore General Hosp. | | | Maryland 24-02 | | |
| 5. SEX | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| F. White | | | Baltimore 21230 | | |
| 6. RACE | | | D. STREET ADDRESS (If rural, give location) | | |
| W | | | 1414 Webster St. | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | E. DATE OF BIRTH | | |
| W | | | 12-8-1891 | | |
| 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 9. AGE (In years last birthday) | | |
| | | | 74 | | |
| 10. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | |
| | | | Baltimore, Md | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| | | | Brickley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| No | | | | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH | | |
| Family - Jane | | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | |
| | | | (A) DUE TO | | |
| | | | Pneumonia | | |
| | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | 3 wks. | | |
| | | | (B) DUE TO | | |
| | | | | | |
| | | | (C) DUE TO | | |
| | | | | | |
| | | | II | | |
| | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| | | | Chronic Myocardial Degeneration | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 2 | | | | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| Yes | | | 2 yr. | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| | | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 12-13 1965 to 12-22 1965, that (X) (we) last saw the deceased alive on 12-22 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| A.C. SOLLOD | | | 12-23-65 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| A.C. SOLLOD M.D. | | | 707 E. FORT AVE - 30 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| B | | 12/27/65 | | Glen Haven | |
| 24D. LOCATION (City, town, or county) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Baltimore | | | | 96500 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | | | 4645 - 130 E. Fort Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13127 | |
|--|-----------|--|-----------------------------|--|---|
| BIRTH NO. 65 13127 | | M.E. CASE NO. | | 12-21-65 | |
| 1. NAME OF DECEASED (Type or Print) HOLMES, Mary | | 2. DATE AND HOUR OF DEATH 12/21/65 | | 7:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | A. STATE MARYLAND B. COUNTY 12-06 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 521 W. 27th Street - 21201 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5/10/84 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME MOONEY, John | | 14. MOTHER'S MAIDEN NAME Agnes | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Septicemia (B) DUE TO Diabetes Mellitus (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH Unknown. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary Tract infection & Decubitus Ulcers. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/29 19 65 to 12-21 19 65, that (I) (we) last saw the deceased alive on 12-21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Patrick Caulfield | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) J. Patrick Caulfield | | 23D. ADDRESS M.D. 4940 Eastern Ave., Baltimore, Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY or CREMATORY ST MARK'S CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR R. L. S. G. G. G. | |
| 25C. FUNERAL DIRECTOR R. L. S. G. G. G. | | 25D. ADDRESS 3617 Chestnut Ave. | | | |

11-24-42

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13128 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| EVA E DIEHLMANN | | 12 18 65 | | 10:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| ST. AGNES HOSPITAL BALTIMORE, MD | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1908 LISMORE LANE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days Hours Min. |
| FEMALE | WHITE | WIDOWED | 8-23-87 | 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| HOUSEWIFE | | | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| HENRY WHITEHEAD | | RIDGWAY, MARGARET REBECCA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | NONE | | Mrs Margaret Snuder 1908 Lismore Lane ST. AGNES HOSPITAL RECORDS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 15-4X I | | Anemia 2 wks to surgery | | | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | YES | YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 11-30 19 65 to 12-18 19 65, that (X) (we) last saw the deceased alive on 12-18 19 65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Steve C. Papastephanou | | | | 12/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| STEVE C. PAPASTEPHANOU | | ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| BURIAL | Dec 22, 1965 | Meadowridge Mem. Park | Howard City. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| | | Hasting Funeral Home | | 736 Edmonson Ave., Catonsville | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

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|---|-------------------------|---|---------------------------------------|--|--|
| BIRTH NO. 65 13129 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13129 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ELLA SMITH | | 2. DATE AND HOUR OF DEATH 12-21-65 4:25 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2636 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6218 Shipview Way 21224 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 12-19-1895 | 9. AGE (in years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George Smith | | | |
| 14. MOTHER'S MAIDEN NAME Ella Baylis | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X1 Sepsis from Decubitus Diabetes + ASCVD | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 days 15 yrs | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-3 1965 to 12-21 1965 , that (I) (we) last saw the deceased alive on 12-20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alan E. Oestrich | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) Alan E. Oestrich | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-23-65 | | 24C. NAME OF CEMETERY or CREMATORY Woods Chapel Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR Walter Dabrowski | | ADDRESS 1005 Dundalk Ave. | |

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ELCA SMITH

Specs from Theodore
Diabetes + ASCVD

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15-51

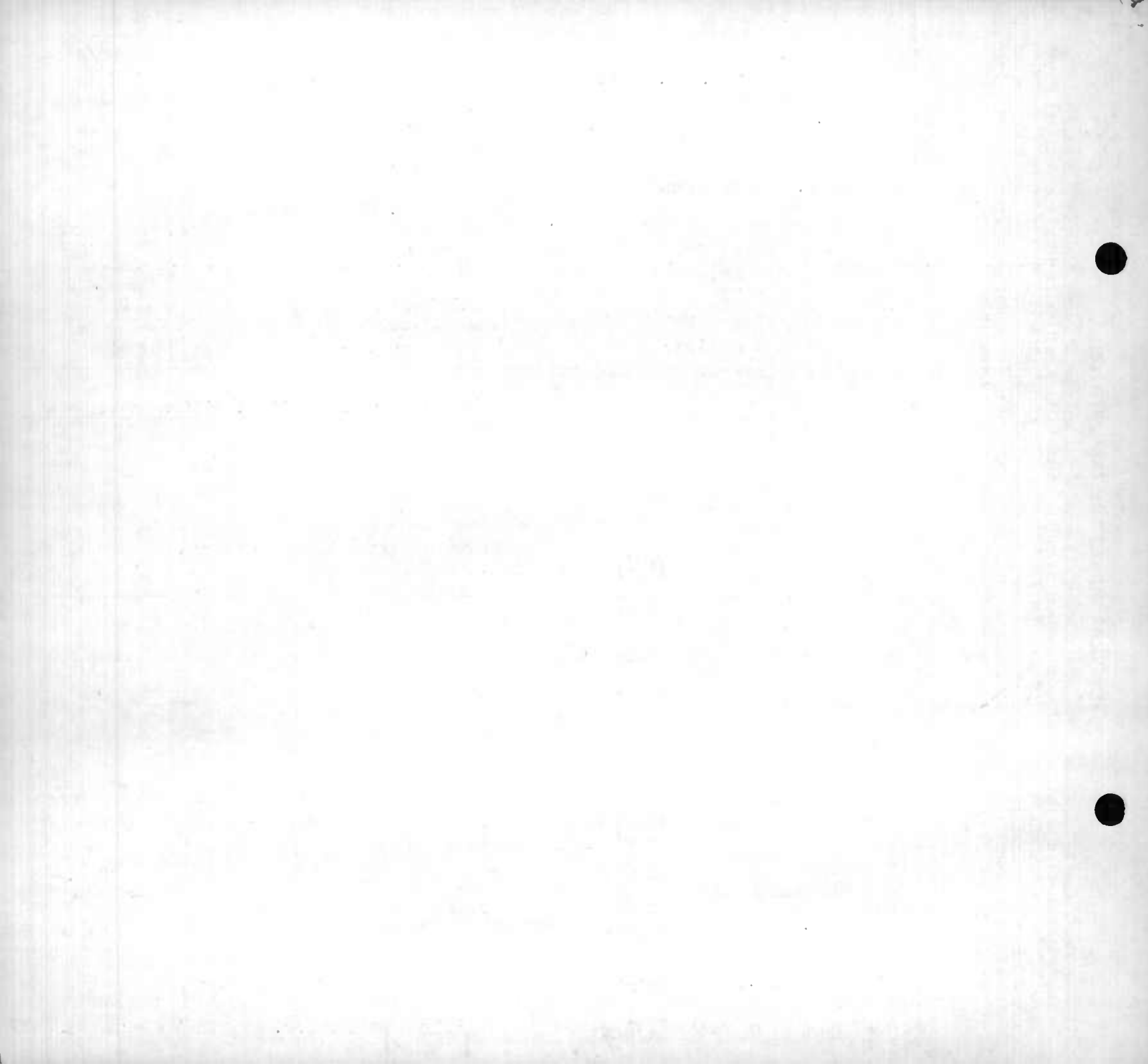
15-51

Robert C. Smith

15-51-62

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13130 | |
|---|--|--|--|--|--|
| BIRTH NO. 65 13130 | | CERTIFICATE OF DEATH | | Registered No. 65 13130 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EDWARD J. A. SCHMEISER | | 2. DATE AND HOUR OF DEATH December 23, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION 12 N. Milton Avenue | | A. STATE Maryland | | B. COUNTY 6-02 | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | |
| 8. DATE OF BIRTH April 17, 1877 | | 9. AGE (In years last birthday) 88 | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Can Processer | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME John Schmeiser | | 14. MOTHER'S MAIDEN NAME Anna Kresser | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Miss Esther Duke 12 N. Milton Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Arteriosclerotic C-V Disease Generalized arteriosclerosis (B) Congestive Heart Failure Coronary arteriosclerosis (C) Pericarditis Cerebral arteriosclerosis Bilateral Blindness - Glaucoma | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from Dec. 14 1965 to Dec. 23 1965, that (I) (we) lost saw the deceased alive on Dec. 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kenneth Krulvitz M.D. | | 23B. DATE SIGNED 12/24/65 | | 23C. PHYSICIAN'S NAME (Type) Kenneth Krulvitz M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-24-1965 | | 24C. NAME OF CEMETERY OR CREMATORY Trinity | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR R. E. J. J. J. | | 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901 Eastern Ave. | |
| 25D. LOCATION (City, town, or county) Baltimore, Maryland | | 25E. ADDRESS 1901 Eastern Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

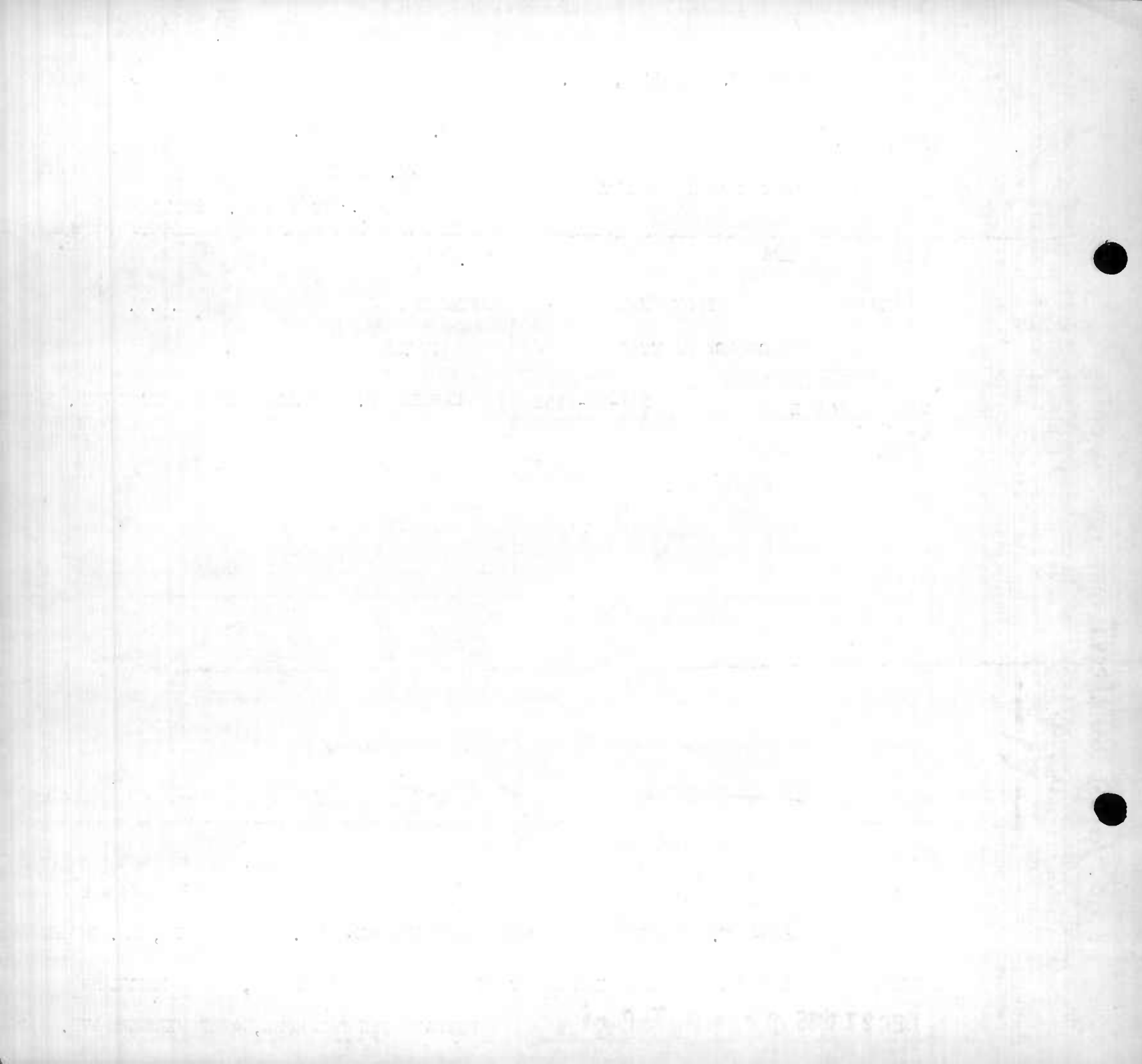
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13131 | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 65 13131 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) SADIE T. ALSO LIZETTA T. SMITH | | 2. DATE AND HOUR OF DEATH DECEMBER 18, 1965 3 P. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1117 S. CAREY STREET | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 1117 S, CAREY STREET 21223 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH JAN. 7, 1886 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GERMANY | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME GEORGE ZIMMERMAN | | 14. MOTHER'S MAIDEN NAME ELIZABETH MEISTER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-48-0923 | | 17. INFORMANT ADDRESS MRS. MARGARET WALDSCHMIDT, 24 DELLWOOD AVE. | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | CAUSE OF DEATH (A) DUE TO Arteriosclerotic Heart Disease with | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. nutritional stenosis | | (B) DUE TO nutritional stenosis | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/20/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8 19 51 to 12/18 19 65 , that (I) (we) last saw the deceased alive on 12/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE John P. Urlock Jr. | | | | 23B. DATE SIGNED 12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN URLOCK | | | | 23D. ADDRESS 1227 WASHINGTON BLVD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/21/65 | | 24C. NAME of CEMETERY or CREMATORY WESTERN CEMETERY | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|---|--|--|--|--|--|---------------------------------------|--|
| 65 13132 | | | | | 65 13132 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| HENRY G. SAUTTER, SR. | | | | | 12/17/65 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SAINT AGNES HOSPITAL | | | | | A. STATE MD. B. COUNTY BALTO. | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) ST. DENNIS | | | | | D. STREET ADDRESS (If rural, give location) 1843 SUTTON AVE. 21227 | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH FEB. 21, 1898 | | 9. AGE (In years lost birthday) 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY POST OFFICE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME GEORGE SAUTTER | | | | | 14. MOTHER'S MAIDEN NAME MARIE | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W L | | | | | 16. SOCIAL SECURITY NO. 214-38-9102 | | 17. INFORMANT CARRIE E. SUATTER | | |
| 18. <u>332 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>Cerebral Thrombosis</u> DUE TO (B) <u>Arteriosclerosis</u> DUE TO (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Myocardial Infarction</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 20</u> 19 <u>57</u> to <u>12/17</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>John C. Healy</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | | | 23B. DATE SIGNED <u>12/17/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) JOHN C. HEALY | | | | | 23D. ADDRESS 1311 FRANCIS AVE. HALETHORPE, MD. 21227 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29 | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--|---|---|
| 65 13133 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13133 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | HARRY CHARLES WARNER | | 2. DATE AND HOUR OF DEATH DECEMBER 17, 1965 9:18P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL | | A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1031 DOWNTON ROAD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9-12-15 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY CALVERT DISTILLERY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? US | | | | | |
| 13. FATHER'S NAME HENRY G. WARNER WARNER | | | 14. MOTHER'S MAIDEN NAME SUSAN L. BROCKMAN ANNA STOCKMAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) YES WORLD WAR 2 | | 16. SOCIAL SECURITY NO. 216-05-6815 | | 17. INFORMANT EVELYN C. WARNER 1031 DOWNTON ROAD ST. AGNES RECORDS WILKENS AND CATON | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Inter cerebral Hemorrhage.</i> DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from DECEMBER 14 1965 to DECEMBER 17 1965, that (X) (we) last saw the deceased alive on DECEMBER 17 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Rafael H Marin</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) RAFAEL H MARIN | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/21/65 | | 24C. NAME of CEMETERY or CREMATORY LOUDON PARK CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR <i>R. A. E. Taylor</i> | | 25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229 | |

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[REDACTED]
[REDACTED]

QUALITY CONTROL

WASHINGTON, D.C.

UNITED STATES

TO: [REDACTED]

FROM: [REDACTED]

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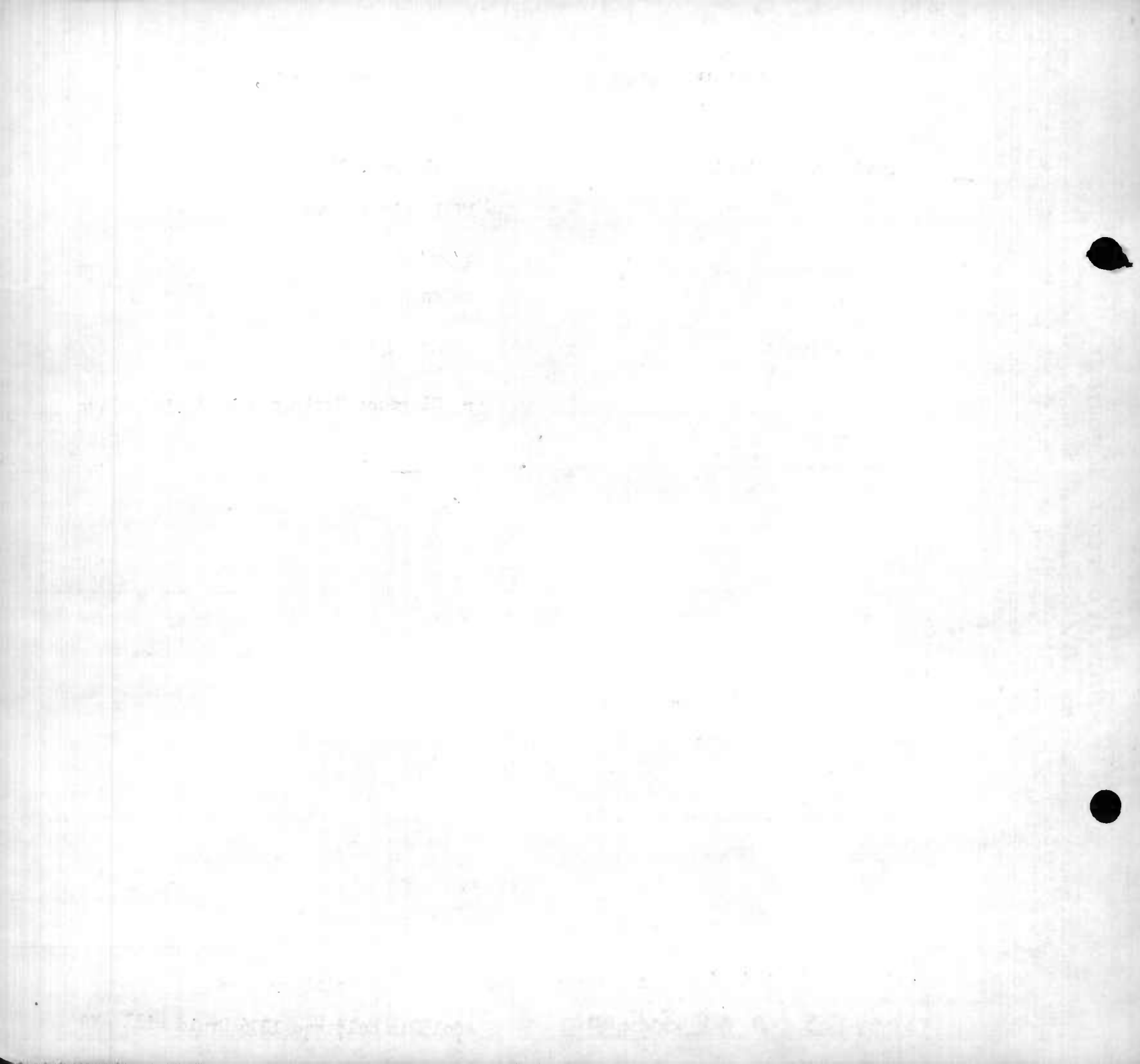
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13134 | |
|--|---------------------|---|------------------------------------|--|--|
| BIRTH NO. 65 13134 | | CERTIFICATE OF DEATH | | Registered No. 65 13134 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Virginia Covington | | 2. DATE AND HOUR OF DEATH December 19, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital | | A. STATE Md B. COUNTY 14-01 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 17 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1721 Linden Ave | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 1/27/06 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Camden N J | |
| 13. FATHER'S NAME Samuel Garnett | | 14. MOTHER'S MAIDEN NAME Sarah Garnett | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr Clarence Covington 1721 Linden Ave | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction | | CAUSE OF DEATH (A) DUE TO Myocardial infarction (B) DUE TO Disease (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH Unk | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/17/65 to 12/19/65 that (I) (we) last saw the deceased alive on 12/17/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. Garner | | | | 23B. DATE SIGNED 12/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) W. GARNER | | | | 23D. ADDRESS 1005 W 2nd Ave Fayette | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery | |
| 24D. LOCATION Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | |
| 25B. NAME OF REGISTRAR Adolphus Halstead | | 25C. FUNERAL DIRECTOR ADDRESS 1206 Druid Hill Ave | | | |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13135 | |
|---|---------|---|---|--|--|
| M.E. CASE NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| Mary DELLA THOMAS | | | December 22, 1965 8:30 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 2839 Denham Circle | | | Maryland | | |
| | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 2839 Denham Circle | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Female | Negro | Widowed | ? | 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Domestic | | | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Unknown | | | Unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 212-32-0453 | | Mrs Mary Della Smith 2839 Denham Circle | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) Arteriosclerotic Cardiovascular Disease. DUE TO | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | (B) DUE TO | | |
| | | | (C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| | | | | DATE SIGNED 12/23/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/24/65 | | Mt. Auburn Cemetery | |
| 23D. LOCATION (City, town, or county) (State) | | 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| Baltimore Md | | DEC 27 1965 | | Adolphus Halstead 1206 W North Ave | |

WALTER B. BOWMAN

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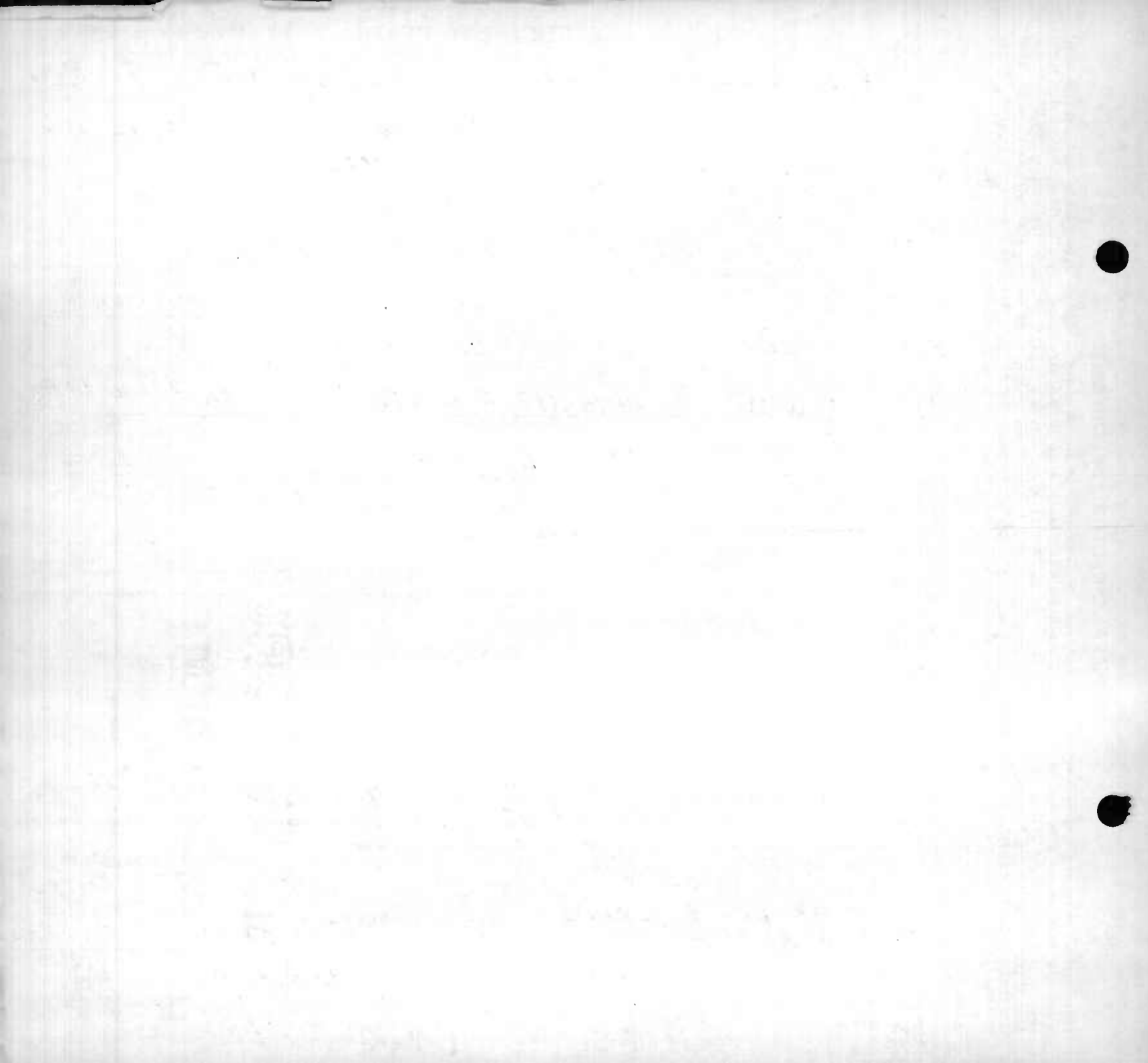
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|----------------------|--|---|--|--|
| BIRTH NO. 65 13136 | | CERTIFICATE OF DEATH | | Registered No. 65 13136 | |
| M.E. CASE NO. 1 | | | 2. DATE AND HOUR OF DEATH DEC. 18-1965 9 PM | | |
| 1. NAME OF DECEASED (Type or Print) ROBERT ELIAS KELLY | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL HOSPITAL | | | A. STATE MARYLAND B. COUNTY 27-48 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 613 E. GITTINGS AVE. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 1-21-07 | 9. AGE (In years lost birthday) 58 YEARS | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PENSIONED | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? AMERICAN |
| 13. FATHER'S NAME ELIAS KELLY | | | 14. MOTHER'S MAIDEN NAME ELIZ. HANSON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 216-14-6697 | 17. INFORMANT ADDRESS FLORENCE R. KELLY - SISTER 233 W. LAFAVETTE AVE. | | |
| 18. 442 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) UREMIA HYPERTENSIVE RENAL CARDIOVASCULAR DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 7 1965 to DECEMBER 18 1965 , that (we) last saw the deceased alive on DECEMBER 18 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Carl E. Arana M.D. | | | | 23B. DATE SIGNED DEC. 18-1965 | |
| 23C. PHYSICIAN'S NAME (Type) FOR DR. A. HURWITZ: DR. C. E. ARANA M.D. | | | | 23D. ADDRESS NORTH CHARLES GENERAL HOSPITAL CHARLES ST. at 28 ST. Balto. 18 Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-21-65 | | 24C. NAME OF CEMETERY or CREMATORY Old Oakland Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Carroll Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Carl E. Arana | | 25C. FUNERAL DIRECTOR Harry Hight Sykesville, Md. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. | |
|---|--------------|--|-------------------------------|---|---|
| BIRTH NO. 65 13137 | | CERTIFICATE OF DEATH | | 65 13137 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) VERA P. BALL | | 2. DATE AND HOUR OF DEATH 12/26/65 7:39 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 27-15 | |
| | | D. STREET ADDRESS (If rural, give location) 2112 SOUTH RD | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12/2/1895 | 9. AGE (In years last birthday) 70 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME WILLIAM RICHARDS | | 14. MOTHER'S MAIDEN NAME LYDIA SAVAGE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT HUSBAND | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 331X1 INTRACEREBRAL + SUBARACHNOID HEMORRHAGE 7 1/2 Hrs | | CAUSE OF DEATH (A) DUE TO SUBARACHNOID HEMORRHAGE (B) DUE TO ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE (C) | | INTERVAL BETWEEN ONSET AND DEATH 7 1/2 Hrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/20/65 to 12/20/65, that (I) (we) last saw the deceased alive on 12/20/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald Feldner | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 24 Dec 65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR A.C. & S. J. 30540 | |
| 25C. FUNERAL DIRECTOR Burgee Funeral Home | | 25D. ADDRESS 3631 Falls Road | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

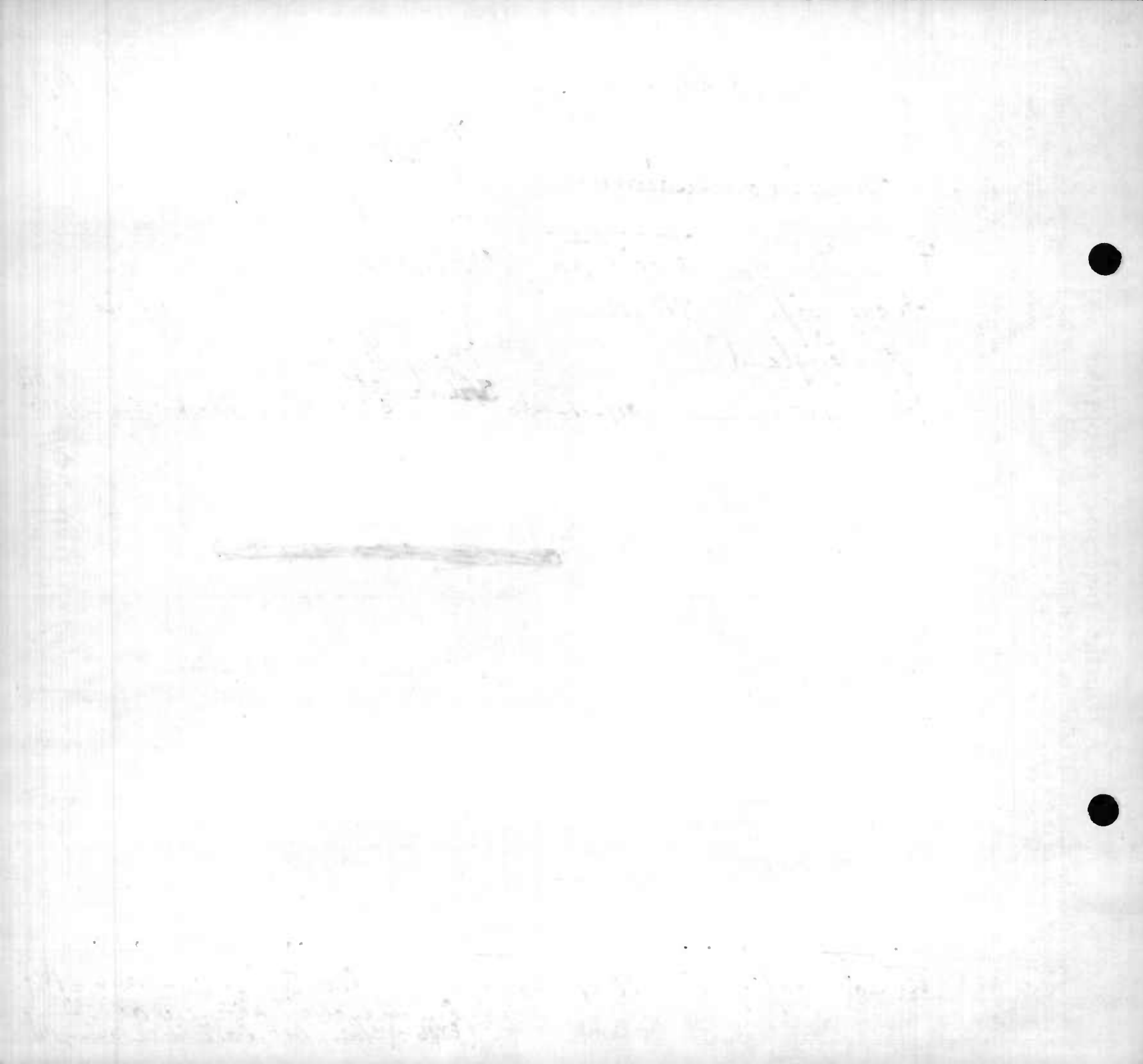
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|--|---|--|--|
| BIRTH NO. 65 13138 | | Registered No. 65 13138 | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Melva Maxine Butts | | 2. DATE AND HOUR OF DEATH Dec. 22, 1965 12: 10 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st St. | | A. STATE W. Va. B. COUNTY V-45 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Martinsburg | |
| | | D. STREET ADDRESS (If rural, give location) 409 S. Raleigh Street | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3/26/25 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 40 |
| 11. BIRTHPLACE (State or foreign country) W. Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Mervil A. Lawrence | | 14. MOTHER'S MAIDEN NAME Nora Puttrel | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None | | 16. SOCIAL SECURITY NO. 234-24-4945 | |
| 17. INFORMANT | | ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH One week | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Generalized lymphosarcoma 5 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from Nov. 4 19 65 to Dec. 22 19 65 , that (1) (we) last saw the deceased alive on Dec. 22 19 65 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Charles J. Lusch</i> | | 23B. DATE SIGNED 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) Charles J. Lusch, Surgeon (R) | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12-24-65 | 24C. NAME OF CEMETERY or CREMATORY ROSEDALE | 24D. LOCATION (City, town, or county) (State) Martinsburg W. VA. |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | 25B. NAME OF REGISTRAR Robert E. ... | 25C. FUNERAL DIRECTOR REAGIN B. ... | |

Charles F. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

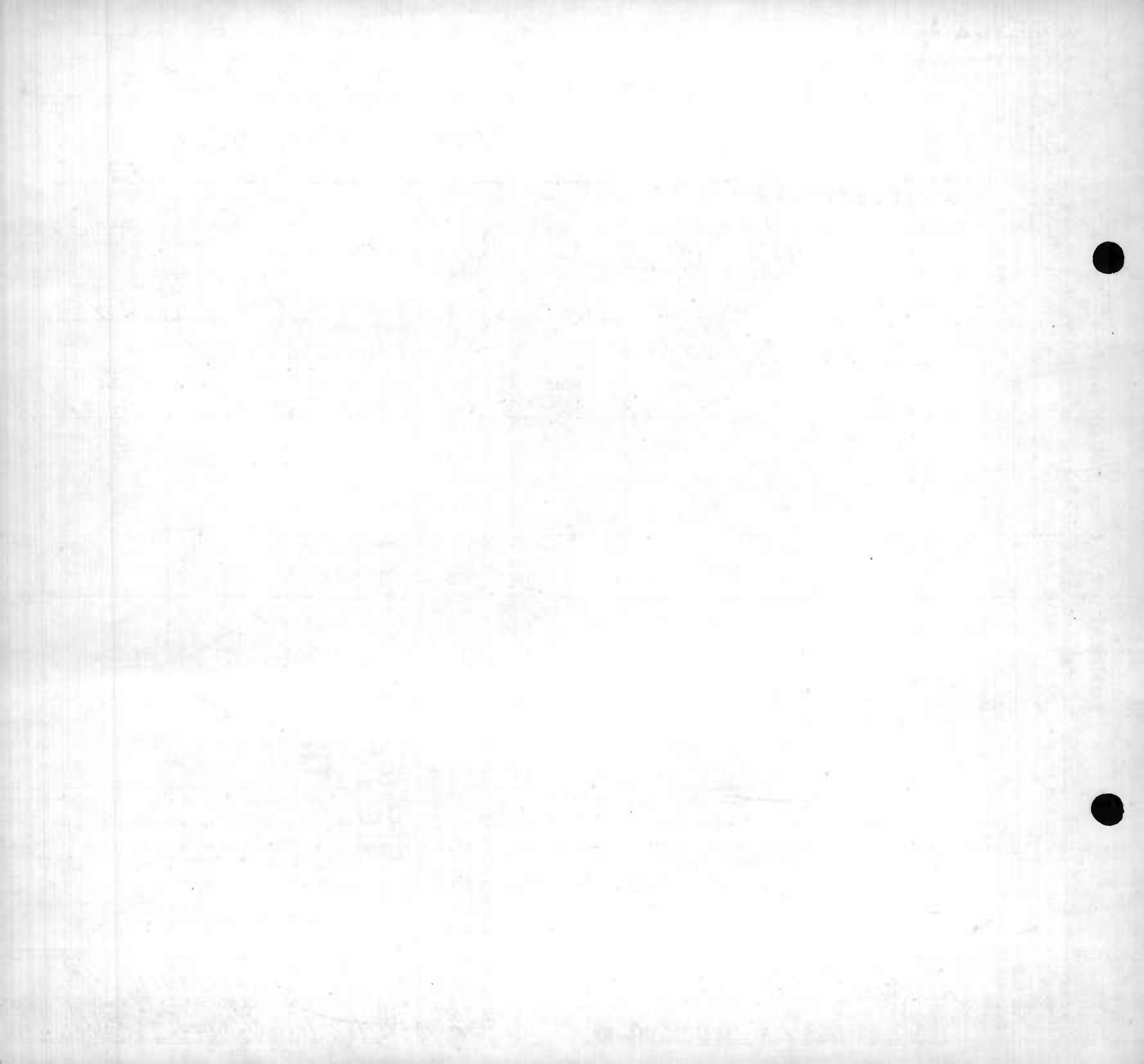
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13139 | | CERTIFICATE OF DEATH | | Registered No. 65 13139 | |
|---|---------------------|---|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Mary A. Glashoff</i> | | | | 2. DATE AND HOUR OF DEATH <i>Dec 18-1965 3:45 AM M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Gould's Convalescenc</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>4501 - Powell Ave</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>12/29/1885</i> | 9. AGE (In years, last birthday) <i>80</i> | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore 212 - Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John England</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Lewis</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>917-01-3230</i> | | 17. INFORMANT <i>Edna att</i> | | ADDRESS <i>6238 - Belair Rd - Baltimore 21206</i> | |
| 18. <i>334X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Atherosclerosis, senile</i> (B) <i>Cerebrovascular apoplexy</i> 36 hr. (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i> | | 20A. AUTOPSY? (Yes or No) <i>-</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>-</i> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>-</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i> | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>We -</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>-</i> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-27-65</i> to <i>12-18-65</i> , that (I) (we) lost saw the deceased alive on <i>12-17-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>V. Sadarananda</i> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12-20-65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>V. Sadarananda, M.D.</i> | | | | 23D. ADDRESS M.D. <i>6801 Belair Rd., Baltimore 6, Md.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/21/1965</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore - 21206 - Md</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>R. O. E. E. E.</i> | | 25C. FUNERAL DIRECTOR <i>Carl D. Woberton Funeral Home Inc.</i> | | ADDRESS <i>6326 - Belair Rd - Baltimore 21206 - Md</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

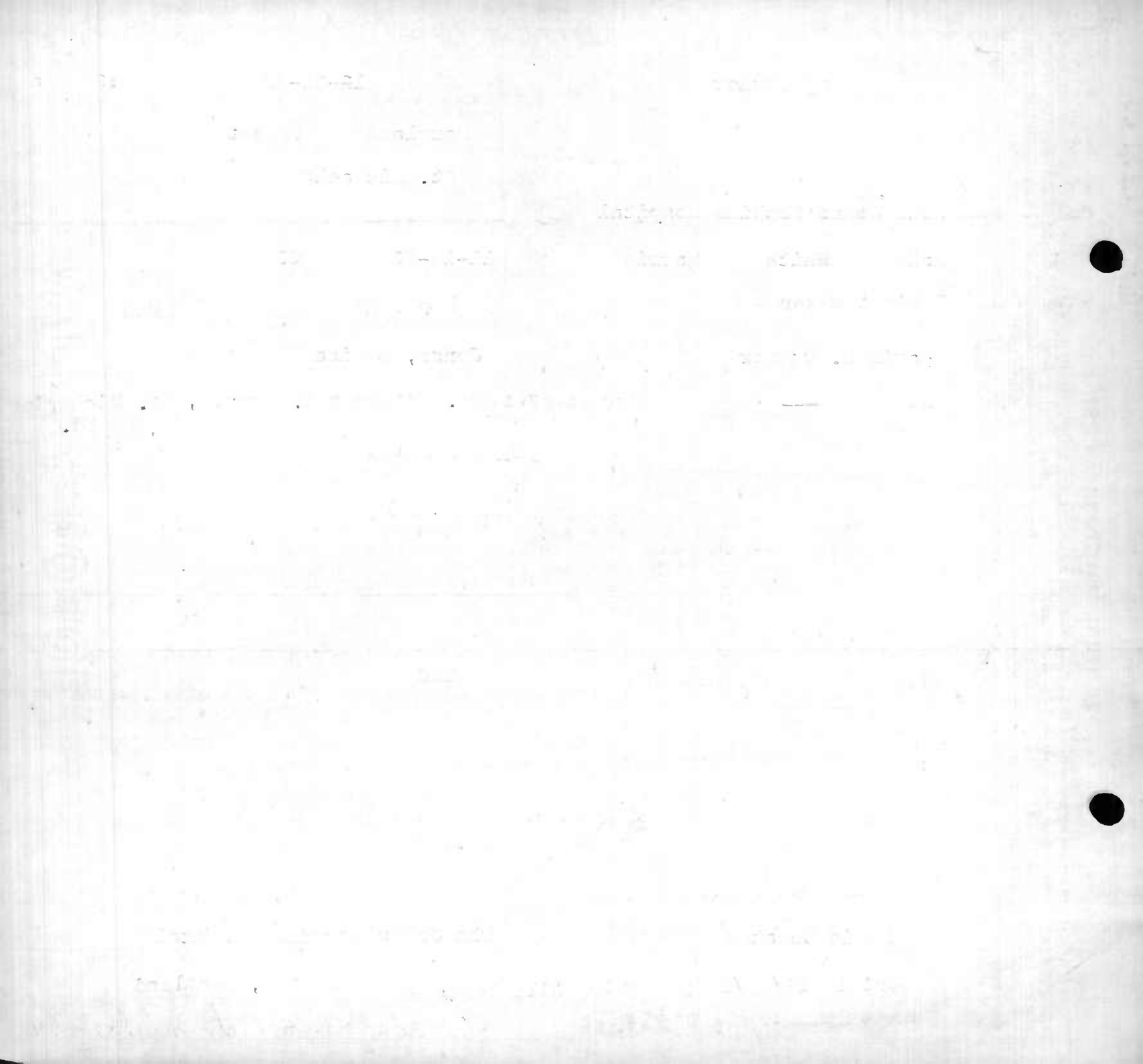
| | | | | | |
|--|-----------|--|--------------------------------|--|--|
| BIRTH NO. 65 13140 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13140 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | M. | |
| 1. NAME OF DECEASED (Type or Print) Mary E. Gruel | | 2. DATE AND HOUR OF DEATH Dec. 20, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Belvedere Nursing Home. | | A. STATE Md. B. COUNTY Baltimore. | | | |
| | | C. CITY OR TOWN (If outside city, limits, write RURAL and give township) Parkton 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) Hillcrest Rd. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed. | 8. DATE OF BIRTH Sept. 3, 1891 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife. Own home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Freeland, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Jacob Measley | | 14. MOTHER'S MAIDEN NAME Sarah Bailey | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 181-032448B | | 17. INFORMANT N. D. Gruel, 3617 Clifmar Rd, Baltimore, Md. 21207 | |
| 18. 15-3-31 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Carcinoma of sigmoid | | 4 1/2 months | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION August 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of sigmoid | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1965 to Dec 20 1965, that (I) (we) last saw the deceased alive on December 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 8:35 PM | | | | | |
| 23A. SIGNATURE Milton Sherry | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec 20, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Milton Sherry | | 23D. ADDRESS 6115 Eastcliff Drive | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-23-65 | | 24C. NAME OF CEMETERY or CREMATORY New Freedom Cemetery | |
| 24D. LOCATION (City, town, or county) New Freedom, Pa. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Jacob Horstman, New Freedom, Pa. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

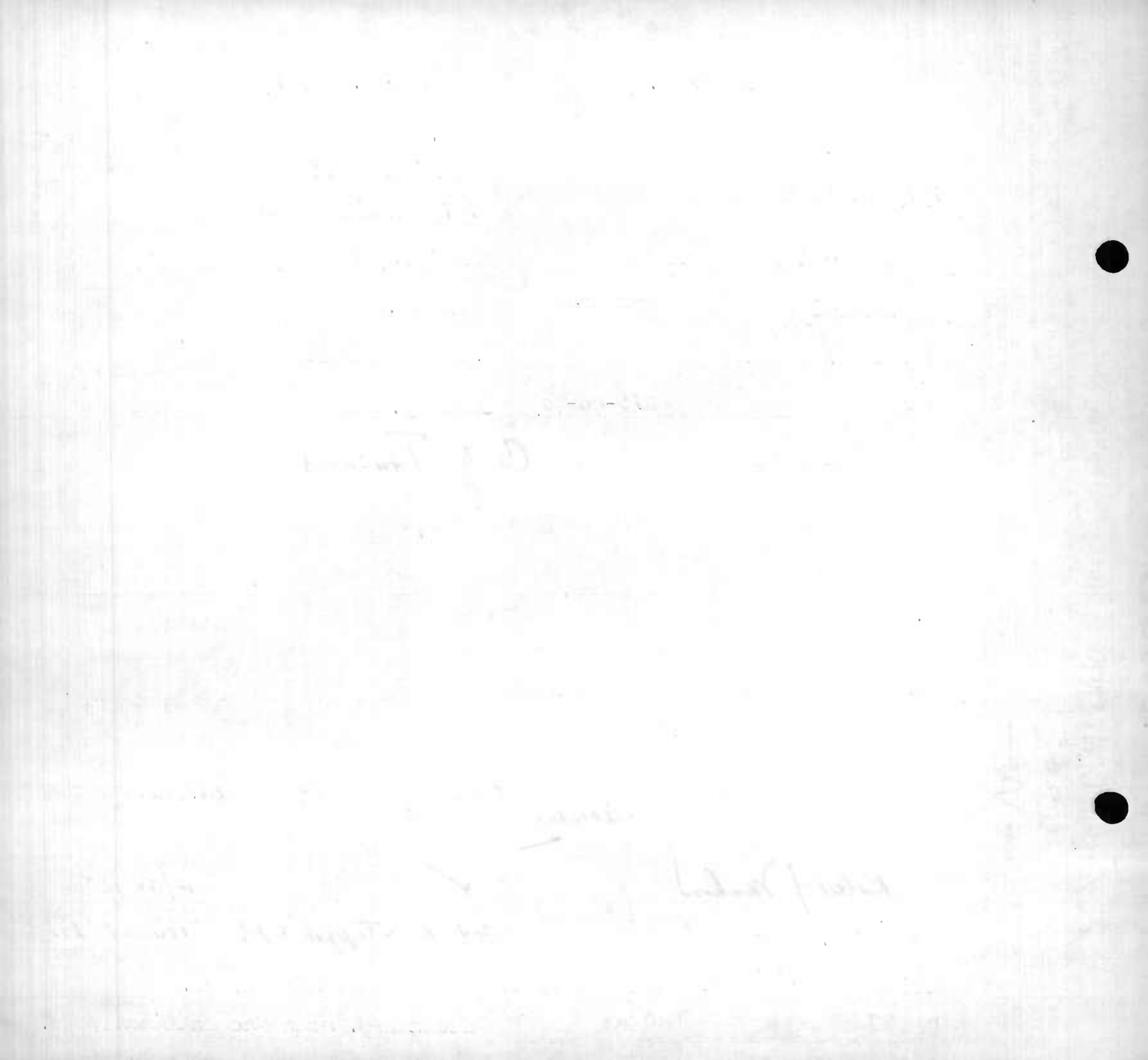
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13141 | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. 65 13141 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Ray Turner | | | 2. DATE AND HOUR OF DEATH 12-21-65 5:20 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Talbot C. CITY OR TOWN (If outside city limits, write RURAL and give township) St. Michaels D. STREET ADDRESS (If rural, give location) 70-00 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11-19-02 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet maker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME David H. Turner | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 14. MOTHER'S MAIDEN NAME Jones, Louisa | | |
| 16. SOCIAL SECURITY NO. 220-16-8782 | | 17. INFORMANT ADDRESS Mrs. Kathleen S. Turner, St. Michaels | | | |
| 18. 344.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hydrocephalus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Emphysema | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Hydrocephalus Emphysema | | |
| INTERVAL BETWEEN ONSET AND DEATH 12-7-65 12-22-65 | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-13-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydrocephalus | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-7-65 19 12-22 19 65 , that (I) (we) last saw the deceased alive on 5:20 a.m. 12-22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sumio Uematsu | | | | 23B. DATE SIGNED 12-22-65 | |
| 23C. PHYSICIAN'S NAME (Type) Sumio Uematsu | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/1965 | | 24C. NAME of CEMETERY or CREMATORY Spring Hill Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Easton, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS St. Michaels Md | |



FUNERAL DIRECTOR: IMPORTANT

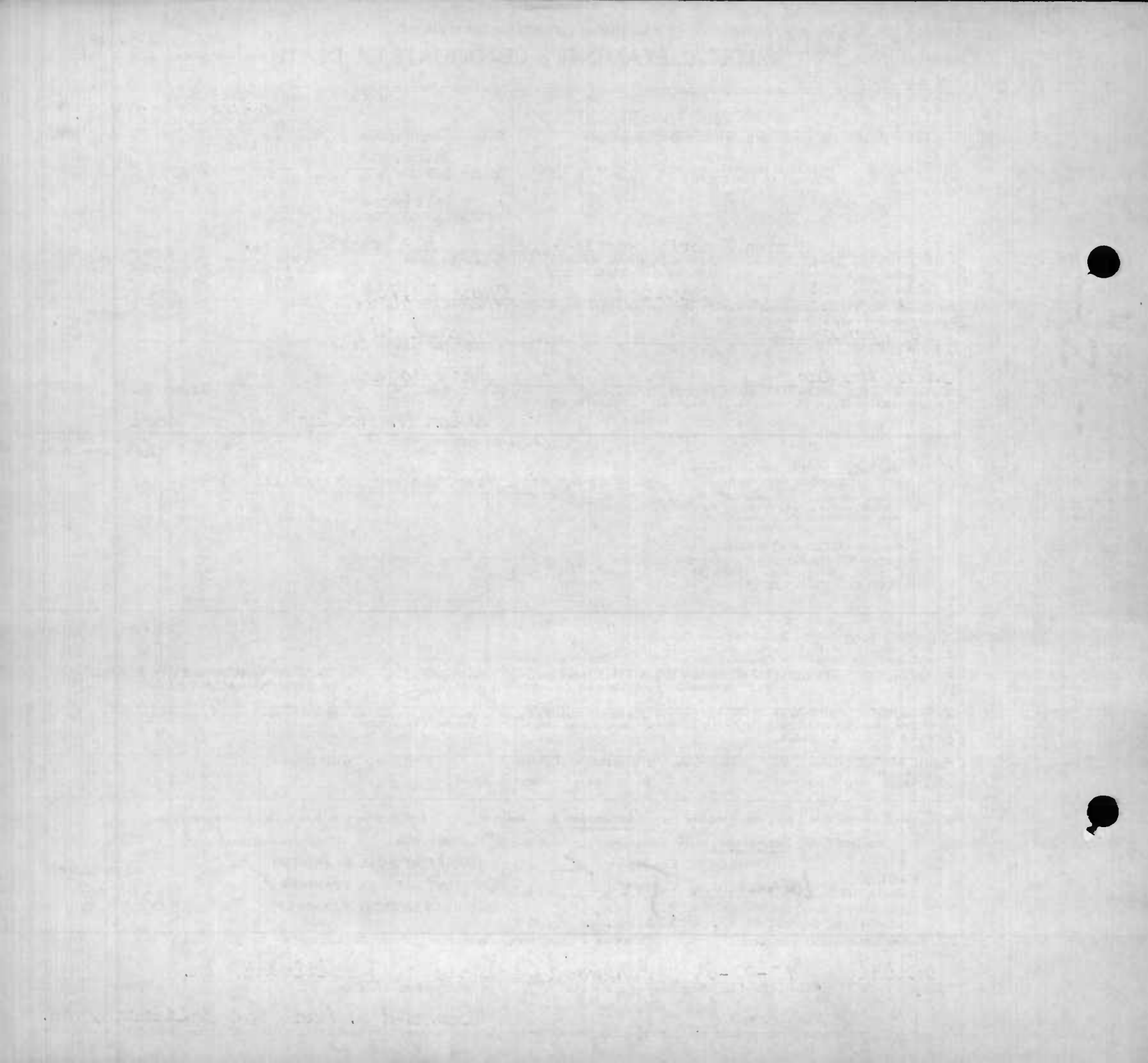
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. 65 13142 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13142 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Eleanor R. Gaeng</i> | | 2. DATE AND HOUR OF DEATH <i>Dec. 23, 1965</i> <i>12 30 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>9-02</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #18</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>1517 Shadyside Road</i> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>1517 Shadyside Road</i> | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED <i>married</i> WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>June 17, 1901</i> | 9. AGE (In years last birthday) <i>64</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Henry Trageser</i> | | 14. MOTHER'S MAIDEN NAME <i>Eleanor Sommers</i> | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-48-4633</i> | | 17. INFORMANT <i>Frank G. Gaeng</i> ADDRESS <i>same</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>13-7X1</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <i>Cag PANCREAS</i> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>OCTOBER</i> 19 <i>65</i> to <i>DECEMBER</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>December</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <i>Robert J. Mahon</i> | |
| 23B. DATE SIGNED <i>12/24/65</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Robert J. Mahon</i> | | 23D. ADDRESS <i>204 E. Joppa Rd Towson Md</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>12/27/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. J. Mahon</i> | |
| 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | | 25D. ADDRESS <i>Baltimore, Md.</i> | | | |



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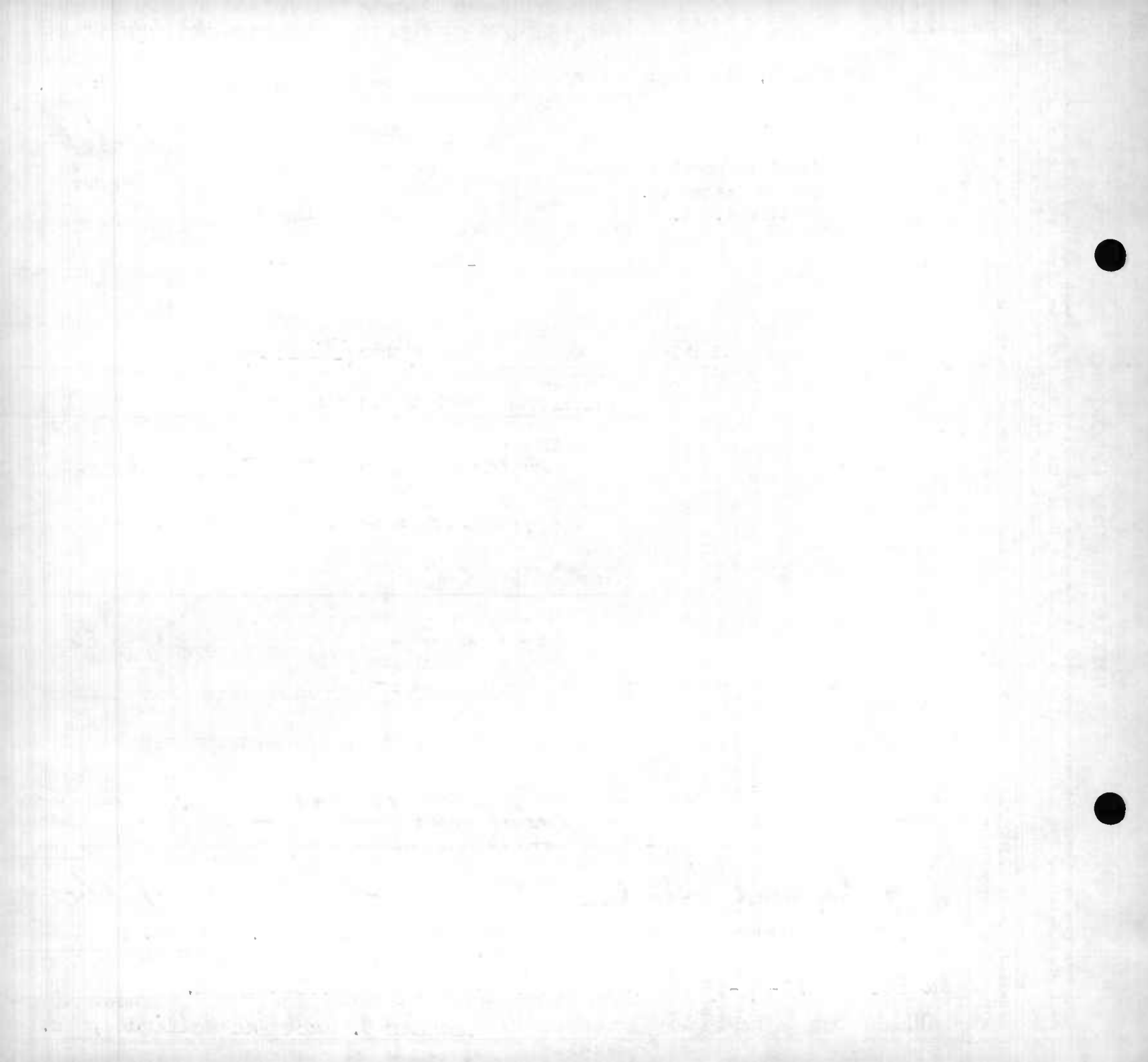
| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|--|------------------|---|---|
| BIRTH NO. 65 13143 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13143 | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) EDWARD HASLUP | | 2. DATE AND HOUR PRONOUNCED DEAD 12/23/65 7:00 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-02 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4419 Frankford Ave. | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH June 23, 1895 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 70 |
| 13. FATHER'S NAME Frank Haslup | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. MOTHER'S MAIDEN NAME Mary Rogers | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Marian H. Haslup same |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO | | | |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/24/65 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) burial | | 23B. DATE 12-27-65 | 23C. NAME of CEMETERY or CREMATORY Parkwood Cemetery |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 24B. NAME OF REGISTRAR Robert E. Spitz | 24C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md. |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. ADDRESS same | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13144 | |
|---|---------------------------|---|---|--|---|
| BIRTH NO. 65 13144 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 1 | | | 2. DATE AND HOUR OF DEATH December 23, 1965 8:50 P. M. | | |
| 1. NAME OF DECEASED (Type or Print) SANDKUHLER, Miss Augusta Mary | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | A. STATE Maryland | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkins Memorial Hospital 1000 S Caton Ave. Baltimore, Md. 21229 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218 | | |
| | | | D. STREET ADDRESS (If rural, give location) 5210 The Alameda | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 1-24-1884 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Francis DeSales Sandkuhler | | | 14. MOTHER'S MAIDEN NAME Anna Fisher (Fischer) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-54-3439 | 17. INFORMANT ADDRESS Medical Records Room | | |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Arteriosclerotic Heart Dis years DUE TO (B) generalized arteriosclerosis years DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH weeks |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. cachexia | | | | | |
| 19A. DATE OF OPERATION 10/13/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED suspected appendicitis | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from Oct 26 19 55 To Dec 23 19 65 , that (H) (we) last saw the deceased alive on 12/23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Raymond Gladue M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 12/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) J Raymond Gladue | | 23D. ADDRESS Jenkins Memorial-1000 S. Caton Ave. 29 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | 24B. DATE 12-27-65 | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>05-13145</u> | |
|--|---------------------|--|-----------------------------------|---|---|
| BIRTH NO. <u>65313415</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>RICHARDSON WILLIAM WINSLOW</u> | | 2. DATE AND HOUR OF DEATH <u>12/23/65</u> <u>3:45</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>27-07</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hosp.</u> | | D. STREET ADDRESS (If rural, give location) <u>2911 Shendale Rd.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>2/2/86</u> | 9. AGE (In years last birthday) <u>79</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Production Manager</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign county) <u>Baltimore, Md</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>Robert Richardson</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura Jackson</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | |
| 16. SOCIAL SECURITY NO. <u>214018203</u> | | 17. INFORMANT <u>J. Marie Richardson</u> | | ADDRESS <u>same</u> | |
| 18. <u>451 X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Renal shut down</u> <u>Ruptured Abdominal Aortic Aneurysm</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <u>profun blood loss</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>12/22/65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>aortic aneurysm</u> | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/22/65</u> to <u>12/23/65</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>C. B. Wallace</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/23/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. C.B. WALLACE, JR.</u> | | 23D. ADDRESS <u>M.D.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>12-27-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u> | |
| 24D. LOCATION <u>Baltimore, Md.</u> | | 24E. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert B. Jackson</u> | | 25C. ADDRESS <u>Leonard J. Ruck Inc Baltimore, Md.</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|--|----------------------------------|--|---|
| BIRTH NO. 65 13146 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13146 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Samuel Gordon Duke, Sr. | | Dec. 22, 1965 | | 10.30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 26-01 | |
| 4300 Arizona Avenue | | C. CITY OR TOWN Baltimore #6 | | | |
| | | D. STREET ADDRESS 4300 Arizona Avenue | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH Oct. 8, 1898 | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Electric Ser. Co. | | 11. BIRTHPLACE (State or foreign country) Penna. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Samuel G. Duke | | 14. MOTHER'S MAIDEN NAME Annie Barrett | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1 | | 16. SOCIAL SECURITY NO. 212-01-2782 | | 17. INFORMANT Mrs. Emma E. Duke | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, or heart failure, asthenia, etc. It means the disease or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO Pneumonia Rtlung (B) DUE TO Pulmonary Emphysema (C) Fracture Hips | | INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs 4-5 mos 5 yrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4300 Arizona Ave | |
| 21D. TIME OF INJURY (APPROX.) August 1965 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fall at Home. 26-01 | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/24/65 19 to Dec 22 19 65, that (I) (we) last saw the deceased alive on Nov 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Milton B. Kress | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) MILTON B. KRESS | | 23D. ADDRESS MEDICAL ARTS BLAG BALTO MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/65 | | 24C. NAME of CEMETERY or CREMATORY Balto. National Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert J. [unclear] | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd. | |
| | | | | ADDRESS | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|---|------------------------------------|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 13147 | | | | |
| BIRTH NO. 65 13147 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) DI PAULA, ANDREW J. | | | | | 2. DATE AND HOUR OF DEATH 12/22/65. 16:35 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP. (If not in hospital or institution, give street address or location) | | | | | A. STATE MARYLAND | | | | |
| | | | | | B. COUNTY BALTIMORE | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3023 ORLANDO AVE. | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | | 8. DATE OF BIRTH 9/12/02 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAFOOD MERCHANT | | | 10B. KIND OF BUSINESS OR INDUSTRY RETAIL | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME SALVATORE DI PAULA | | | | | 14. MOTHER'S MAIDEN NAME ROSA ? D'Antoni | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 213-05-0329 | | 17. INFORMANT ROSEMARY SCHISLER | | | ADDRESS (Same) | |
| 18. 522.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Cor Pulmonale (A) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH unk | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Emphysema (B) DUE TO | | | | | unk | | | | |
| (C) _____ | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that the (this hospital) attended the deceased from 12/8 19 65 to 12/22 19 65 , that the (we) last saw the deceased alive on 12/22 19 65 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Robert N. Whitlock | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT WHITLOCK | | | | | 23D. ADDRESS Union Memorial Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12/27/65. | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214 | | | | |

DI PAULA, ANDREW E.

APPOINTED
BALTIMORE

3023 ORANGE AVE

4/15/03

USA

MARYLAND

POST 3

POSTWARD CENTER

Office for Baltimore

Office for Baltimore

UNION MEMBER

M W

STATED MEMBER

DI PAULA

NO

15/55

15/55

15/55

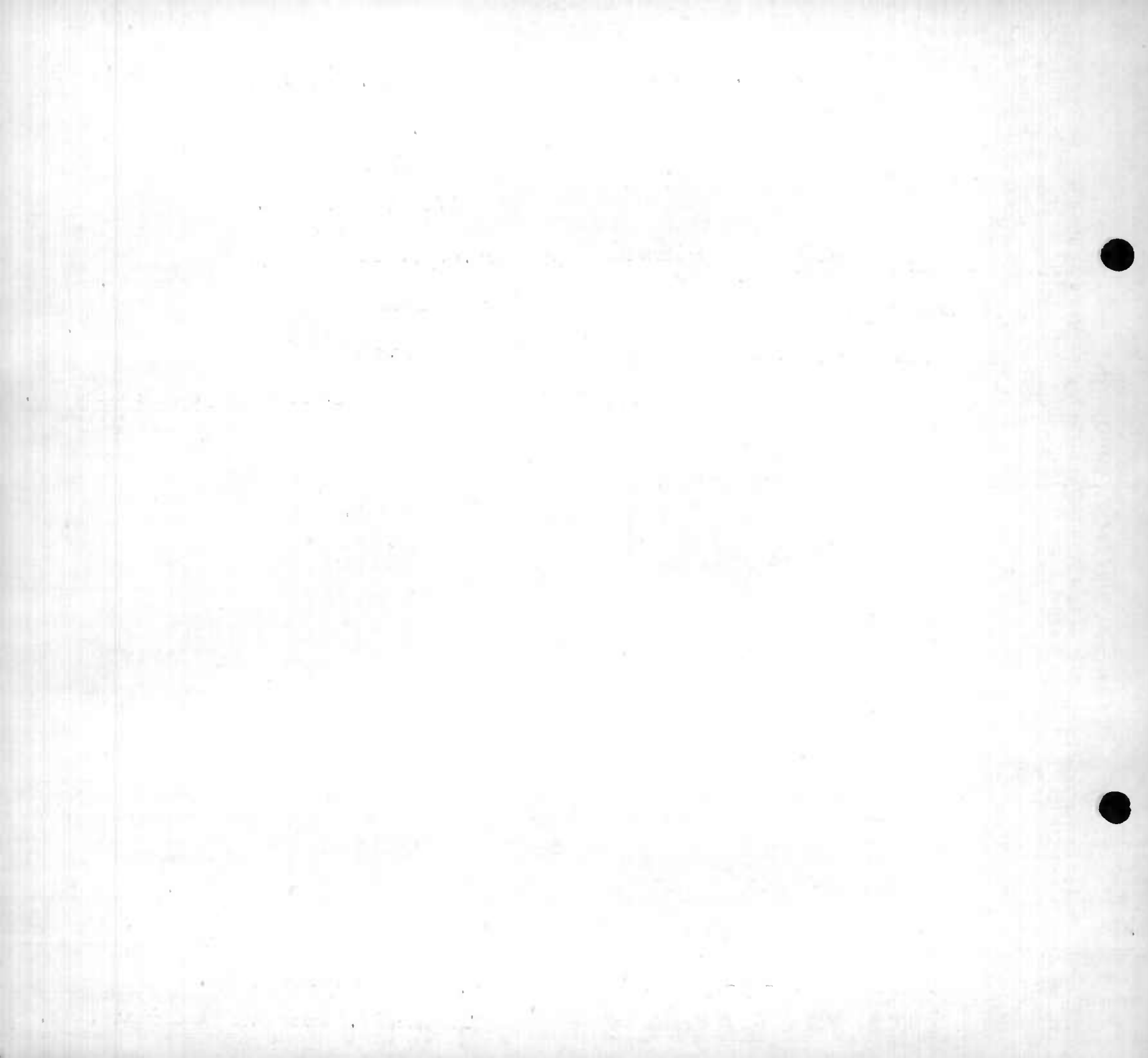
15/55

Post 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

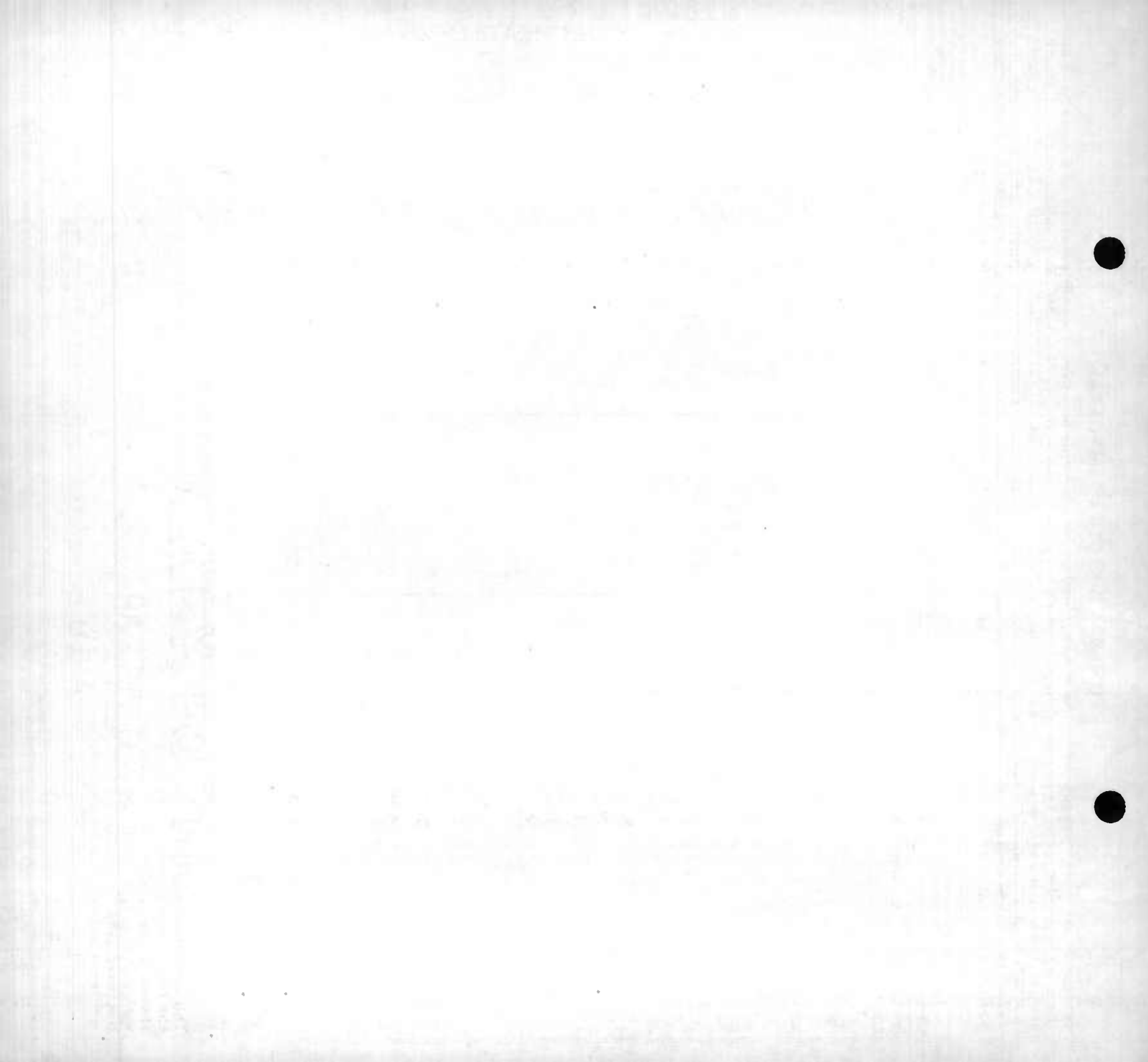
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|---|--|---|--|--|--|
| BIRTH NO. 65 13148 | | CERTIFICATE OF DEATH | | | | Registered No. 65 13148 | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Rose S. Keyser</i> | | | | 2. DATE AND HOUR OF DEATH <i>Dec. 23, 1965</i> <i>9:30 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i> | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-44</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>6218 Everall Ave.</i> | | | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>Nov. 13, 1888</i> | 9. AGE (In years lost birthday) <i>77</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>Henry Schubert</i> | | | 14. MOTHER'S MAIDEN NAME <i>Not known</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <i>219182082</i> | | 17. INFORMANT <i>Mrs Andrew Zell</i> | | ADDRESS <i>6203 Golden Ring Rd.</i> | | |
| 18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>10 Yrs.</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>Oct 15 1965</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Oct 15 1965</i> to <i>Dec 23 1965</i> , that (I) was last saw the deceased alive on <i>Dec 15 1965</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Charles M. Kerry</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | 23B. DATE SIGNED <i>Dec 24, 65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Charles M. Kerry</i> | | | 23D. ADDRESS <i>6801 Belair Rd Bk 2 to 6</i> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>12-27-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Jones</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | | ADDRESS <i>Baltimore, Md.</i> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

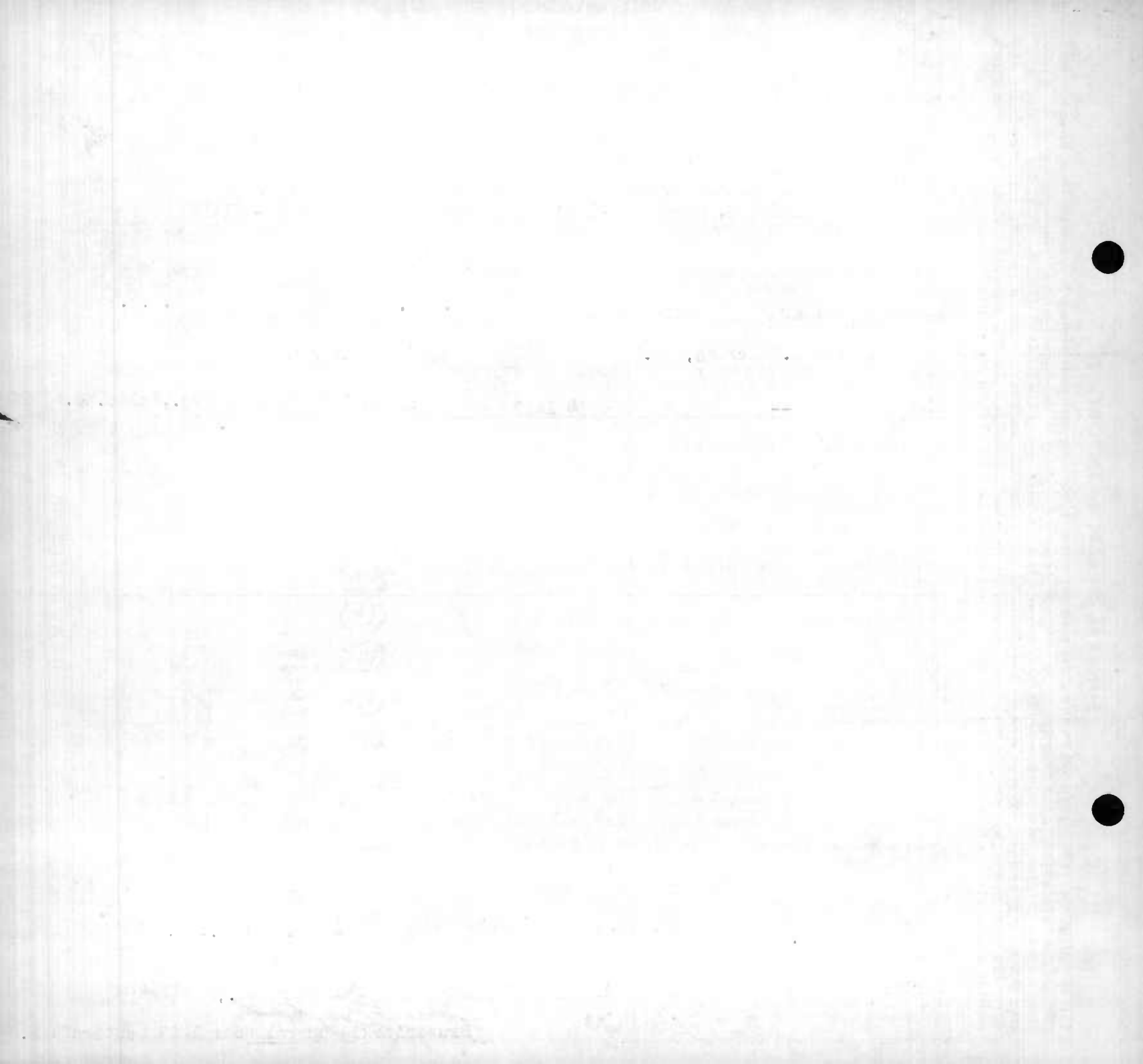
| 65 13149 BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13149 | |
|---|--|---|--|---|--|
| BIRTH NO. | | | | DATE AND HOUR OF DEATH | |
| M.E. CASE NO. | | | | 12-24-65 10:10 A.M. | |
| 1. NAME OF DECEASED (Type or Print) <i>Thomas Jones</i> | | | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE <i>Maryland</i> B. COUNTY <i>24-04</i> | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | |
| <i>South Baltimore General Hosp</i> | | | | <i>Baltimore #21230</i> | |
| 5. SEX <i>M.</i> 6. RACE <i>W.</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M.</i> | | | | 8. DATE OF BIRTH <i>9-1-1892</i> 9. AGE (In years last birthday) <i>73.</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Steel Co.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Family</i> | | | | ADDRESS <i>Same</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) <i>Carcinoma of stomach</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <i>a widespread metastases</i> | |
| II | | | | (C) <i>Hydropneumothorax secondary to A.</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that we (this hospital) attended the deceased from <i>12-13</i> 19 <i>65</i> to <i>12-24</i> 19 <i>65</i> , that we (we) last saw the deceased alive on <i>12-24</i> 19 <i>65</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Robert R. Holtzhaus</i> M.D. | | | | 23B. DATE SIGNED <i>12-24-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert R. Holtzhaus</i> M.D. | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12 27 65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olivet</i> | |
| 24D. LOCATION (City, town, or county) <i>Balto. Md.</i> | | 24E. (State) <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>McTully</i> ADDRESS <i>130 E. Fort Ave.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY DEPARTMENT | | Registered No. | |
|--|---------|--|--|--|--|
| H-255 | | 65 13150 | | 65 13150 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| STEWART D. HICKMAN, JR. | | | 12-24-65 1:15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| BALTIMORE CITY HOSPITALS | | | MARYLAND BALTIMORE | | |
| 4940 Eastern Avenue | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| Baltimore, Maryland 21224 | | | 5300 | | |
| D. STREET ADDRESS (If rural, give location) | | | 2400 LINCOLN AVENUE - 21219 | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| M | W | MARRIED | 11/11/35 | 30 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Mechanics Helper | | Steel Mill | | W. VA. | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Stewart D. Hickman, Sr. | | | U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| Bernice Chapman | | | No -- | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| 236 54 1217 | | | RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224 | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 12-22-65 | | Pulmonary Embolus | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-26-65 to 12-24-65 1965, that (I) (we) last saw the deceased alive on 12-24-65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. Patrick Caulfield M.D. | | | | 12-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| J. Patrick Caulfield | | | | M.D. 4940 Eastern Avenue, Balto., Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/27/65 | | Holly Hill Memorial Gardens | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 27 1965 | | J. Patrick Caulfield | | Braudzinski Funeral Home 1407 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 65 13151 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13151 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Shapiro, Michael | | 2. DATE AND HOUR OF DEATH 12/25/65 1 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Md Baltimore | | 27-17 | |
| D. STREET ADDRESS (If rural, give location) 2919 Oakley Ave. | | 5. SEX M | | 6. RACE W | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 4/15/1884 | | 9. AGE (In years, lost birthday) 84 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JACOB | | 14. MOTHER'S MAIDEN NAME MARY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-38-3340 | | 17. INFORMANT SARAH SHAPIRO | |
| ADDRESS 2919 OAKLEY | | 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO Septicemia | | | |
| ANTECEDENT CAUSES | | (B) DUE TO Urinary Tract Infection | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If yes, medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work Not While At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that this hospital attended the deceased from 12/20 to 12/25 1965, that (I) last saw the deceased alive on 12/24 1965 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death. | | 23A. SIGNATURE Leonard J. Heetzberg M.D. Attending Phys. Med. Director Staff Phys. 102-25-65 | | 23B. DATE SIGNED 12-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) Leonard J. Heetzberg M.D. | | 23D. ADDRESS Sinai Hospital Balt, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/26/65 | | 24C. NAME OF CEMETERY or CREMATORY Bnai Israel | |
| 24D. LOCATION Baltimore | | 24E. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 24F. NAME OF REGISTRAR R. E. Taylor | |
| 24G. FUNERAL DIRECTOR ADDRESS 3319 Olympia Ave | | 24H. NAME OF REGISTRAR R. E. Taylor | | 24I. FUNERAL DIRECTOR ADDRESS 3319 Olympia Ave | |

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1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|--|--|---|---|--|---|--|
| BIRTH NO. 65 13152 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 13152 | |
| 1. NAME OF DECEASED (Type or Print) LEVIN, HYMAN | | | | | 2. DATE AND HOUR OF DEATH 12-23-65 7 45 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland , B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #18 D. STREET ADDRESS (If rural, give location) 2027 St. Paul St | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, (NEVER MARRIED) WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 1891 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: Hours: Min. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collection agent | | | 10B. KIND OF BUSINESS OR INDUSTRY Collection Agency | | 11. BIRTHPLACE (State or foreign country) Baltimore | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Levin | | | 14. MOTHER'S MAIDEN NAME unknown | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES I | | | 16. SOCIAL SECURITY NO. 216 332-6591 | | 17. INFORMANT Harry M. Walen | | | ADDRESS 5356 Carriage Ct. #29 | |
| 18. 420114-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction | | | | | CAUSE OF DEATH (A) acute myocardial infarction DUE TO (B) QASVD DUE TO (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH many years | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus, mild | | | | | | | | unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION none | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-11-65 to 12-23 19 65 , that (I) (we) last saw the deceased alive on 12-23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Harry M. Walen | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY M. WALEN | | | | | 23D. ADDRESS M.D. 5356 CARRIAGE CT. 21229 Baltimore | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/24/1965 | | 24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP | | | 24D. LOCATION (City, town, or county) (State) BALTO. MD | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | 25B. NAME OF REGISTRAR Robert E. [illegible] | | | 25C. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, INC. ADDRESS 3319 Oldyapia Ave | | | |

under the [illegible]

and



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|--|--|--|--|
| M.E. CASE NO. | | | | 65 13153 | | 65 13153 | |
| 1. NAME OF DECEASED (Type or Print) | | | | MEYERS, RENA LOUISE | | 2. DATE AND HOUR OF DEATH DECEMBER 25, 1965 1:40 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. #29 | | MARYLAND 20-04 | |
| 5. SEX FEMALE | | | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | Domestic | | VIRGINIA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| WILLIAM Taylor | | | | LYDIA | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | None | | ADDRESS #29 ST. AGNES RECORDS-CATON & WILKENS AVES. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH acute diverticulitis poss. LLQ abscess | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO ACVD, Hemiplegia, Hypertension | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Left ventricular hypertrophy Myocardial damage | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from DECEMBER 19 1965 to DECEMBER 25 1965, that (X) (we) last saw the deceased alive on DECEMBER 25 1965 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (XXXX) view the body after death. | | | | | | | |
| 23A. SIGNATURE Marchena | | | | M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| OCTAVIO DE MARCHENA | | | | CATON & WILKENS AVES. BALTO. # 29, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12-29-65 | | Forest Hills | | Green Springs, VA. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | |
| DEC 27 1965 | | R. E. Jenkins | | George L. Schwab Funeral Home Virginia Miller 210, Frederick Ave | | | |

100-27701
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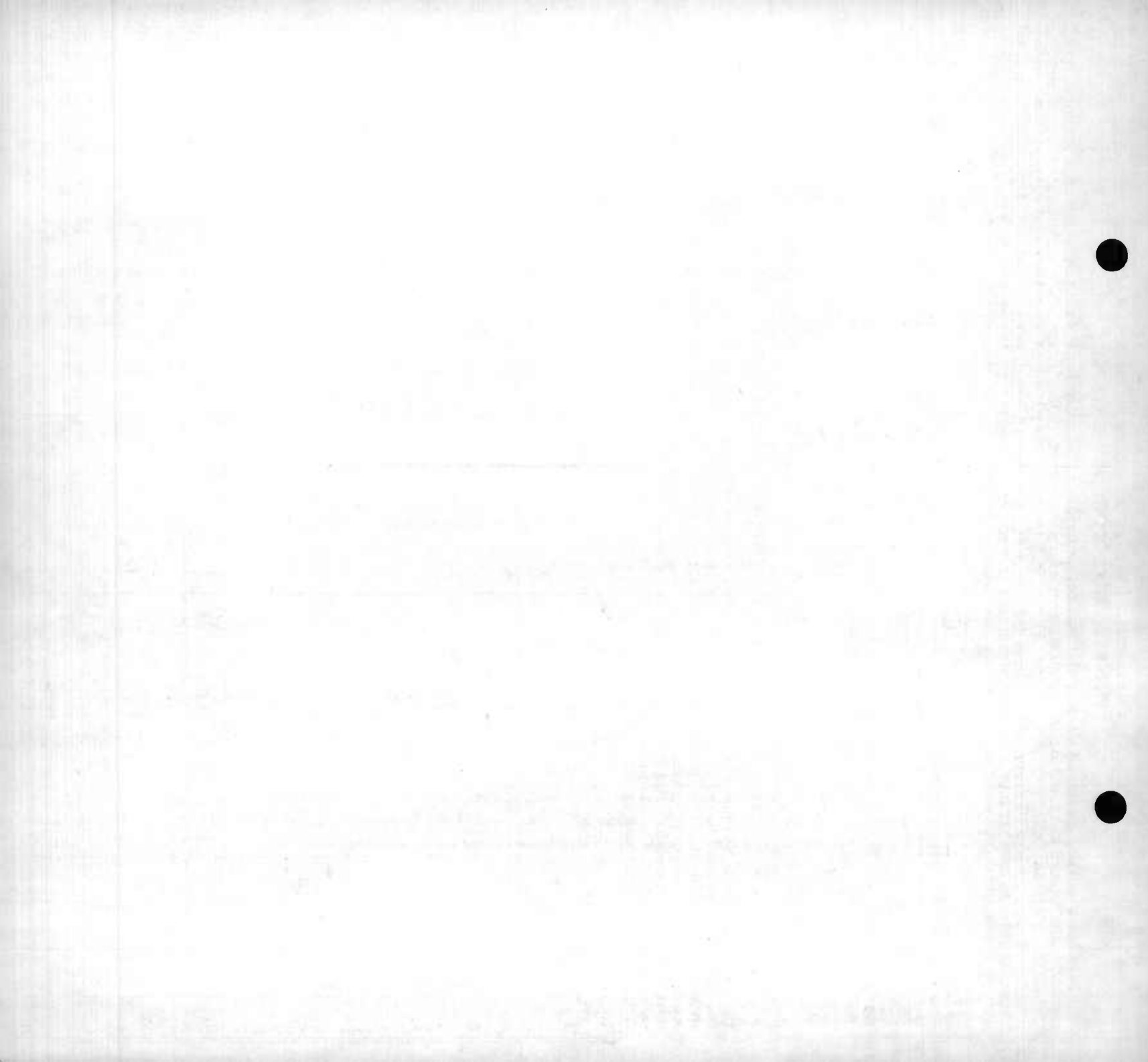
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

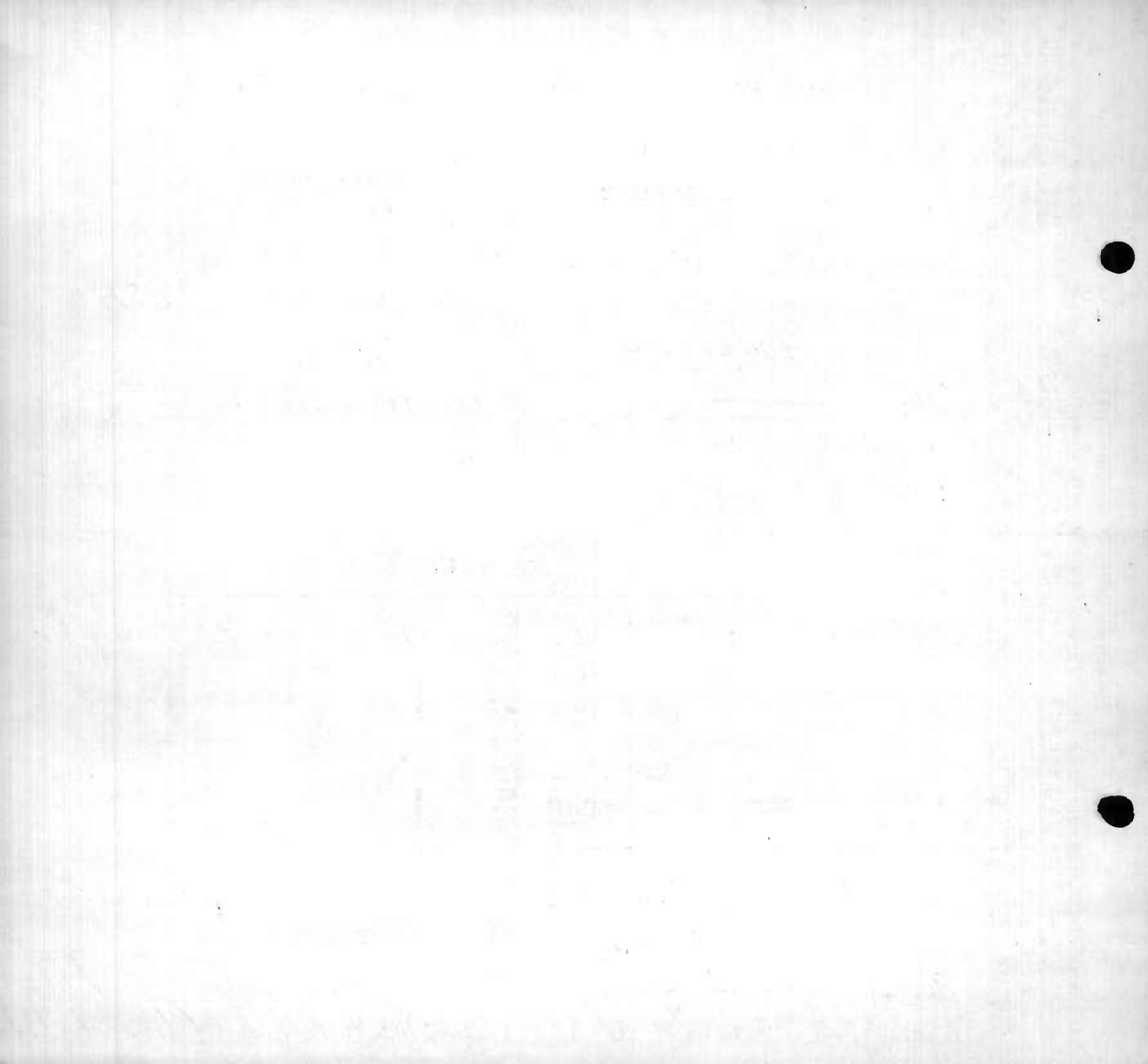
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 13154 | |
|---|--|---|--|---|--|
| BIRTH NO. | | | | 65 13154 | |
| M.E. CASE NO. | | | | 65 13154 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| Henry J Betkey Sr. | | | | 21-Dec 65 8:20 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION If not in hospital or institution, give street address or location | | | | A. STATE B. COUNTY | |
| Maryland General Hospital | | | | Maryland Baltimore | |
| 5. SEX 6. RACE | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| Male White | | | | Baltimore | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | | D. STREET ADDRESS (If rural, give location) | |
| Widowed | | | | 304 S Taylor Ave | |
| 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 8-25-00 | | 65 | | Retired | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Maryland | | USA | | Unknown | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Unknown | | No | | 215-19-4200 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | ADDRESS | |
| Daughter in Law | | 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1 This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension | | 304 S Taylor Ave | |
| Interval between onset and death | | 3 days | | At least 5 years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| No | | No | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| No | | No | | No | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| No | | No | | No | |
| 22. I certify that (I) (this hospital) attended the deceased from 18-Dec 1965 to 21-Dec 1965, that (I) (we) last saw the deceased alive on 21-Dec 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE T.C. Cullis | | | | 23B. DATE SIGNED 21 Dec-65 | |
| 23C. PHYSICIAN'S NAME (Type) T.C. Cullis MD | | | | 23D. ADDRESS Maryland General Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12-24-65 | | Garden of Faith Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| Baltimore, Co. Md. | | DEC 27 1965 | | J. E. Sullivan | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | 25E. ADDRESS | |
| Dormery Funeral Home | | 300 Prince Ave. | | 300 Prince Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13155 | |
|--|-------------------------|--|---|--|--|
| BIRTH NO. 65 13155 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 65 13155 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Rose V. | | MAY | | 2. DATE AND HOUR OF DEATH DECEMBER 23, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 19-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1521 WEST PRATT STREET | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1521 West Pratt St. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-11-1887 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Annapolis, Md. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Isaac Anderson | | | 14. MOTHER'S MAIDEN NAME "UNK." | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Gertrude Wallace #4 | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-Vascular - Many Years | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) Rheumatoid Arthritis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Disabling Rheumatoid Arthritis - Many Years | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from Jan 1960 to Dec. 23 1965 , that (I) (we) last saw the deceased alive on Dec 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Abram Goldman M.D. | | | | 23B. DATE SIGNED 12.23.65 | |
| 23C. PHYSICIAN'S NAME (Type) ABRAM GOLDMAN | | 23D. ADDRESS 4123 FREDERICK AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-27-65 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Bluff | |
| 24D. LOCATION (City, town, or county) (State) Annapolis Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR John M. Keyle | | 25C. FUNERAL DIRECTOR John M. Keyle + Sons Annapolis, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13156 | |
|--|-----------------------------------|--|--|--|---|
| BIRTH NO. 65 13156 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) EARL E. Baldwin | | | 2. DATE AND HOUR OF DEATH 12-20-65 8:30 AM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 28-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5605 Wayne Ave 21207 | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 8-16-1915 | 9. AGE (In years lost birthday) 50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) welder | | 10B. KIND OF BUSINESS OR INDUSTRY W.F. WISSON + Sons Inc. | | 11. BIRTHPLACE (State or foreign country) Indiana | |
| 13. FATHER'S NAME David Baldwin | | | 14. MOTHER'S MAIDEN NAME Pearl Herrin | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-03-5258 | | 17. INFORMANT Mrs. Dorothy A. Baldwin 5605 Wayne Ave. | |
| 18. I 199.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma, neck of metastasis | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-19-65 19 12-20 19 65 , that (I) (we) last saw the deceased alive on 12-20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. Linantud, Jr. | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-20-65 |
| 23C. PHYSICIAN'S NAME (Type) C. LINANTUD, JR. | | | 23D. ADDRESS Bon Secours Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE Dec. 23, 1965 | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR G. Truman Schwab | | 25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 21229 3512 Frederick Ave. | |

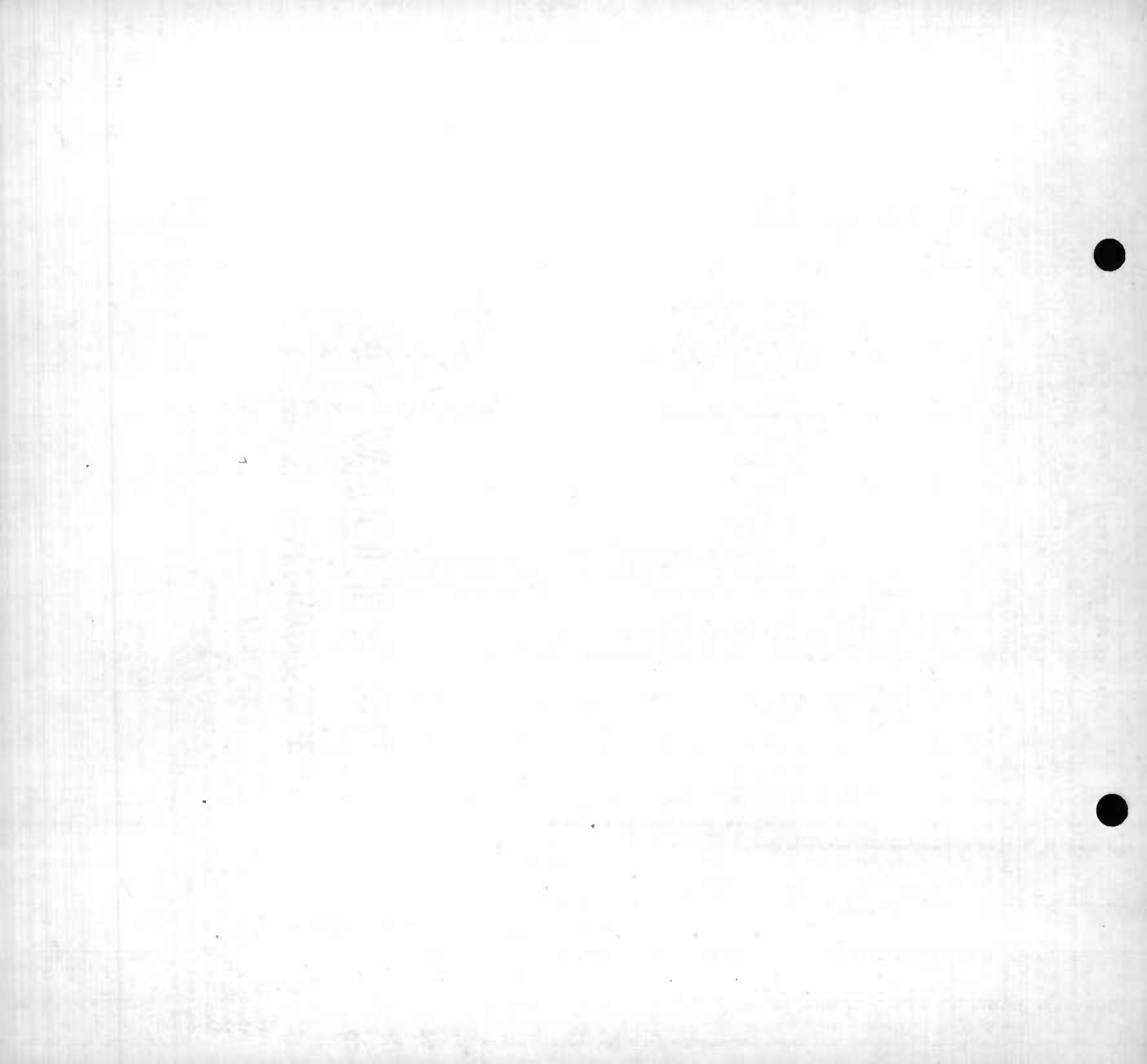
| | | | | | |
|--|---------------|--|---|---|--|
| BIRTH NO. 65 13157 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13157 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM ABENDSCHEIN | | | 2. DATE AND HOUR PRONOUNCED DEAD 12/17/65 12:08 p.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hopkins Hospital | | | A. STATE Maryland | | |
| | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-01 | | |
| | | | D. STREET ADDRESS (If rural, give location) 3041 O'Donnell St. | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 8-14-1901 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Revere Copper | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Deceased | | | 14. MOTHER'S MAIDEN NAME Deceased | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-03-0893 | | 17. INFORMANT ADDRESS Thomas Deegan 3236 Fait Avenue | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) DUE TO | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 12/18/65 | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12-21-1965 | 23C. NAME of CEMETERY or CREMATORY Mt. Carmel Cemetery | | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS Clarence Hoffmann 3218 Hudson St. | |

WALTON FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

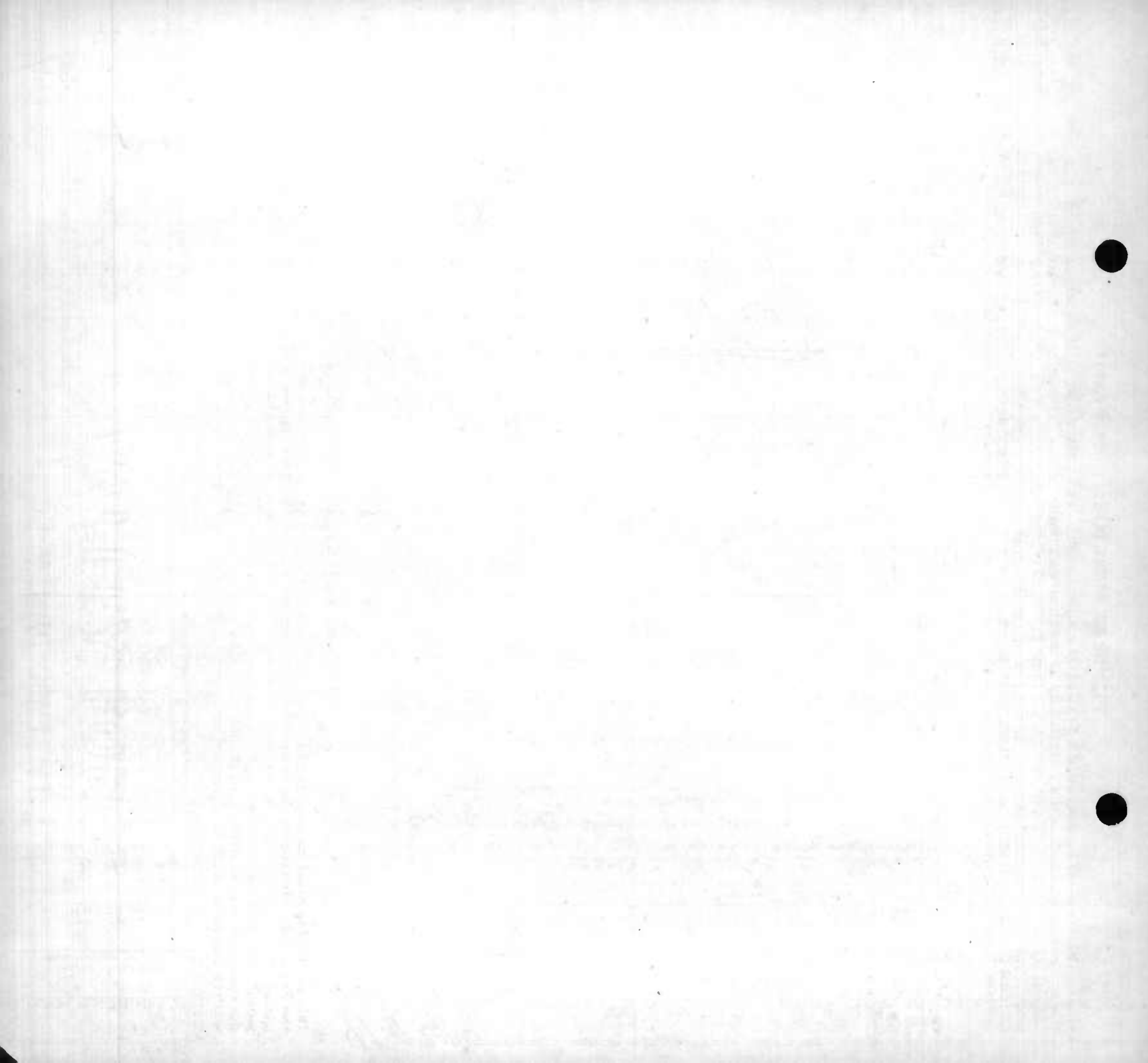
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13158 | |
|---|----------------------|--|------------------------------------|--|--|
| BIRTH NO. 65 13158 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) IDA MAY BURT | | 2. DATE AND HOUR OF DEATH DEC. 17 1965 9:40 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 26-09 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION GOULD'S CONVALESARIUM 6116 BELAIR RD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | | | |
| | | D. STREET ADDRESS (If rural, give location) 3404 ELLIOTT ST. | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 5/10/84 | 9. AGE (In years lost birthday) 81 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME WILLIAM WILLIAMS | | 14. MOTHER'S MAIDEN NAME ELIZ. BAYONNE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. JOHN ERMER | |
| | | | | ADDRESS 3404 ELLIOTT ST | |
| 18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 19 49 to Dec. 19 65 , that (I) (we) last saw the deceased alive on Dec. 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Clarence W. LeDeux | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) Clarence W. LeDeux | | M.D. | | 23D. ADDRESS 3023 Eastern Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN | |
| 24D. LOCATION (City, town, or county) (State) BALTO. Co. MD. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR R. E. S. Johnson | |
| 25C. FUNERAL DIRECTOR George Hoffmann | | ADDRESS 3218 HUDSON ST | | | |



FUNERAL DIRECTOR: IMPORTANT

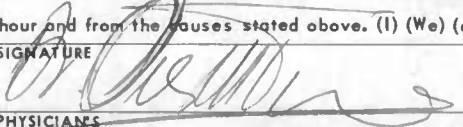
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13159 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13159 | |
|--|-------------------------|--|--|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ELLA PINIECKI | | | | 2. DATE AND HOUR OF DEATH Dec 17, 1965 9:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 HOPKINS HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE MD. | | B. COUNTY 1-02 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3111 Fleet St. | | | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 11/8/92 | 9. AGE (In years last birthday) 73 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME JOHN PINIECKI | | | | 14. MOTHER'S MAIDEN NAME MARY RACZNIAK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT ED. PINIECKI | | |
| | | | ADDRESS 20 PORTSHIP RD. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 42011X-260X | | | CAUSE OF DEATH Coronary Thrombosis | | | INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO Arteriosclerotic Cardiovascular Disease | | | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | | | |
| II | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Diabetes Mellitus | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/17/65 to 12/17/65 that (I) (we) last saw the deceased alive on 12/17/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ed. Piniecki | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS 1116 ST. PAUL ST. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY | | 24D. LOCATION (City, town, or county) (State) BALTO. Co. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. [unclear] | | 25C. FUNERAL DIRECTOR Ed. Piniecki | | ADDRESS 3218 HUDSON ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|--|--|--|----------|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 13160 | | | | |
| BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) | | 65 13160 MEAGER | | | 2. DATE AND HOUR OF DEATH DEC 23 1965 | | 1:45P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 307 BEECHWOOD AVE. | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 3-21-82 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME JOHN WEISBAGER | | | | 14. MOTHER'S MAIDEN NAME MARY — UNKNOWN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE. | | | | | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis - Hypertensive Cardiovascular Disease - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus - | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC 19 1965 to DEC 23 1965 , that (I) (we) last saw the deceased alive on DEC 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE  | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-23-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) PEDRO P. PURCELL, M.D. | | | | 23D. ADDRESS ST. AGNES HOSPITAL, CATON & WILKENS AVE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/27/65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR R. A. E. J. J. J. | | 25C. FUNERAL DIRECTOR E. S. MACNABB | | ADDRESS 301 FREDERICK RD 21228 | | | |

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(COTN 45) LKAD ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 65 13161 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13161 | |
|--|--|----------|--|--|--|-------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | |
| (Type or Print) | | | | MARGARET ANN GEORGE | | | |
| 2. DATE AND HOUR OF DEATH | | | | DECEMBER 13, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 22 E. Mt. Vernon Pl. Baltimore, Md. | | | | Maryland | | | |
| 5. SEX | | | | 6. RACE | | | |
| Female | | | | White | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH | | | |
| Widowed | | | | Dec. 13, 1908 | | | |
| 9. AGE (In years last birthday) | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | |
| 57 | | | | Sales Manger | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Delaware | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Henry C. Gordy | | | | Alice E. Ellis | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | 213-03-402 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Stephen George | | | | 3507 Newland Rd. Baltimore 18, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| No | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (APPROX.) | | | |
| 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 13 1965 to 12-9 1965, that (I) (we) last saw the deceased alive on 12-9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Philip F. Wagley | | | | 12-20-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Philip F. Wagley | | | | 9 East Chase Street Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Burial | | | | 12-20, 1965 | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Jesdop Cemetery | | | | Baltimore Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| DEC 27 1965 | | | | Wm. Cook Brooks | | | |
| 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| Towson, Md. | | | | 1050 York Rd. Towson, Md. | | | |

Service

Persons to be interviewed

(A) 10/1/51

10-1-51

10-1-51

10-1-51

| BIRTH NO. 65 13162 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13162 | |
|--|------------------|--|--|--|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ROBERT RUSHER | | | 2. DATE AND HOUR PRONOUNCED DEAD December 21, 1965 4:10 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3654 Beech Avenue | | | A. STATE Maryland B. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3654 Beech Avenue | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 1-17-1894 | 9. AGE (In years last birthday) 71 | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME JOSEPH RUSHER | | 14. MOTHER'S MAIDEN NAME CARRIE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI | | 16. SOCIAL SECURITY NO. 212-07-8548 | | 17. INFORMANT ADDRESS DELLA MATHIAS 706 W 34TH ST | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/22/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 12-29-65 | | 23C. NAME of CEMETERY or CREMATORY WOODLAWN CEM | |
| 23D. LOCATION (City, town, or county) (State) BALT. MD. | | 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 24B. NAME OF REGISTRAR Robert E. Sisk | |
| 24C. FUNERAL DIRECTOR Paul E. Knowlton | | 24D. ADDRESS 3615 Chestnut Ave | | | |

WALLACE & GORDON

~~RECEIVED~~

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IN

CASE

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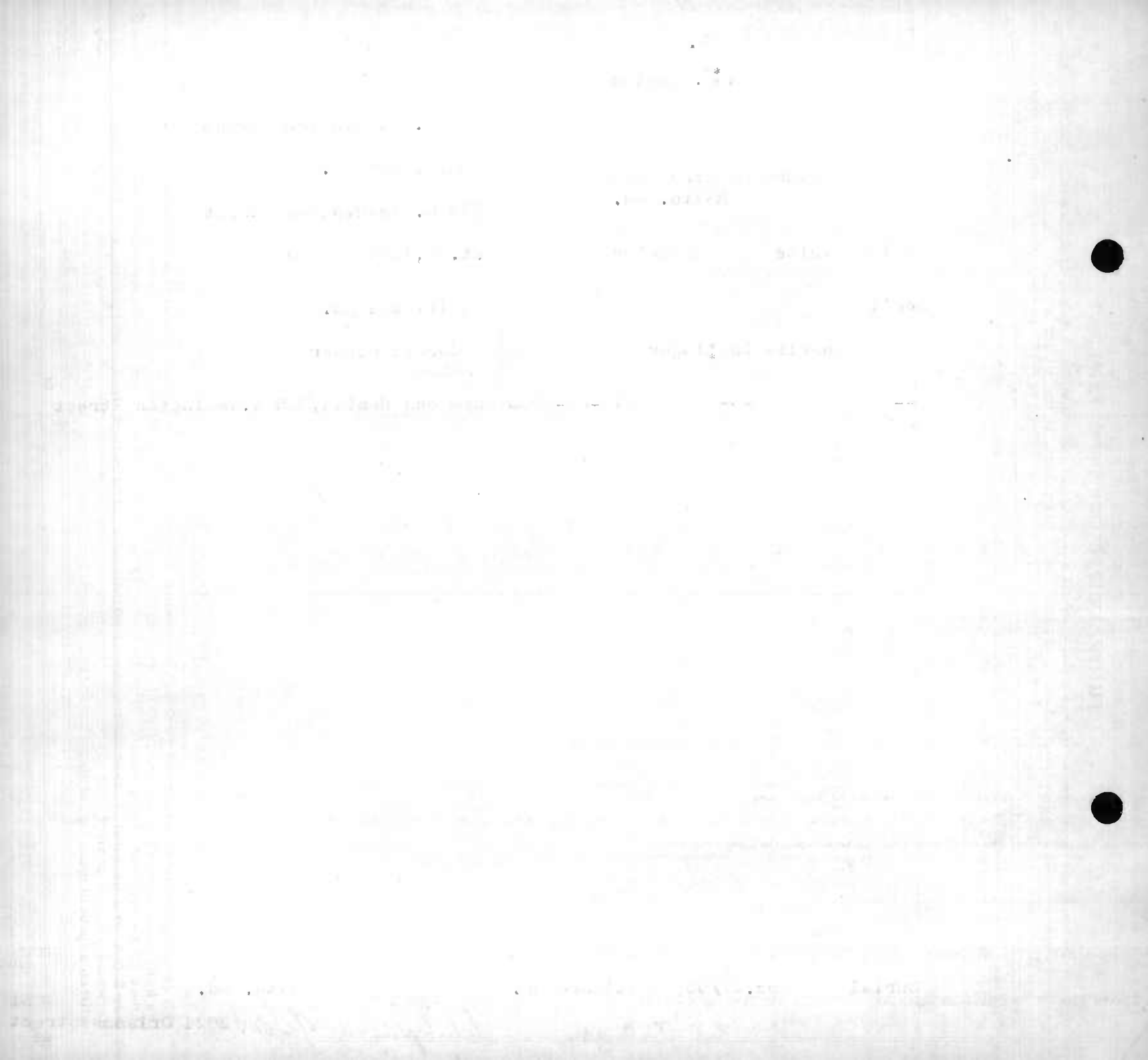
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|-----------------------------------|--|--|
| BIRTH NO. 65 13163 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13163 | |
| M.E. CASE NO. | | L. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Elva M. Benton | | 2. DATE AND HOUR OF DEATH 23 Dec '65 9:30 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hosp Balto. Md. | | A. STATE 525 N. Washington Street | | 7-05 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore d. | |
| | | D. STREET ADDRESS (If rural, give location) | | 525 N. Washington Street | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Oct. 30, 1909 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec't | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | |
| 13. FATHER'S NAME Charles Laufinger | | 14. MOTHER'S MAIDEN NAME Carrie Kerner | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -- | | 16. SOCIAL SECURITY NO. 213-03-3350 | | 17. INFORMANT ADDRESS 5 Raymond Benton, 525 N. Washington Street | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Acute Coronary Occlusion (B) DUE TO Arteriosclerotic degenerative (C) DUE TO C.V. Disease | | INTERVAL BETWEEN ONSET AND DEATH Instant. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3 Dec 1965 to 23 Dec 1965, that (I) (we) last saw the deceased alive on 23 Dec 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph E. Muse Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 24 Dec '65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS 2725 N. Charles St. Balto 18 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 27/65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore Md. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Philip Herwig | |
| 25C. FUNERAL DIRECTOR 2024 Orleans Street | | 25D. ADDRESS 31 | | | |



65 13164

BALTIMORE CITY HEALTH DEPARTMENT

65 13164

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WALERIA (VALERIA) SZEWCZYK

2. DATE AND HOUR PRONOUNCED DEAD

December 22, 1965

11:10 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, 21231

D. STREET ADDRESS (If rural, give location)

724 S. Broadway

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

December, 14, 1888

9. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

- - - - -

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Jankiewicz

14. MOTHER'S MAIDEN NAME

Rose Pacena

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-48-7238

17. INFORMANT

ADDRESS

Andrew A. Jankiewicz 2423 Foster Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/22/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/27/65

23C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cemetery

23D. LOCATION (City, town, or county) (State)

Dundalk Ave-Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

George A. Weber 705 South Ann Street

ADDRESS

George A. Weber

WALLACE FORGIE

1
A-536

65 13165

BALTIMORE CITY HEALTH DEPARTMENT

65 13165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FREDONA E. ANDREWS

2. DATE AND HOUR PRONOUNCED DEAD

December 20, 1965 5:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

103 Ferndale Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

July 29, 1900

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Saleslady

10B. KIND OF BUSINESS OR INDUSTRY

G.C. Murphy Co.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Francis M. Wince

14. MOTHER'S MAIDEN NAME

Nancy A. Riggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

236-12-6518

17. INFORMANT

Mrs. Louella Whaley, 1919 Adelmar Spr. Rd. Landsdown, Maryland

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Right Hemothorax DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rupture of Right Pulmonary Artery. DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Glenwood Ave. & Fourth St., Brooklyn Park

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 12 20 '65 P

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

Dec. 24, 1965

23C. NAME of CEMETERY or CREMATORY

Mt. Carmel Cemetery

23D. LOCATION

(City, town, or county)

Fincsh, West Virginia

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1965

24B. NAME OF REGISTRAR

George J. Gonce

24C. FUNERAL DIRECTOR

George J. Gonce, 4001 Ritchie Hwy.

ADDRESS

Baltimore 25, Md.

VALLEY FORGE

NOV 19 1944

1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|----------------------------|--|---|
| BIRTH NO. 65 13166 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13166 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES A HALE, Sr. | | 2. DATE AND HOUR OF DEATH DECEMBER 16 1965 10:25 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-42 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2753 WEGWORTH LANE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3-9-14 | 9. AGE (in years last birthday) 51 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) OHIO | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME EDWARD HALE | | | |
| 14. MOTHER'S MAIDEN NAME ESTELLE TAYLOR | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 279 03 3742 | | 17. INFORMANT CATON AVENUE ST. AGNES RECORDS -WILKENS AND | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) EMPHYSEMA (R) Due to p.o. (B) Broncho-pulmonary Fistula (C) Contributory coronary arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from OCTOBER 5 1965 to DECEMBER 16 1965, that (X) (we) last saw the deceased alive on DECEMBER 16 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Pedro F. Bajo | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) PEDRO F. BAJO | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 20, '65 | | 24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A.A.Co., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR George J. Gonce | |
| ADDRESS 4001 Ritchie Hgwy. Baltimore 25, Md. | | | | | |

Confession (R) due to 11.01
Bourbon-Grand 11.01
Confession on 11.01

THAT T-110
THAT T-110

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------|--|----------------------------------|--|--|
| BIRTH NO. 65 13167 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13167 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mabel B. Queen | | 2. DATE AND HOUR OF DEATH 12-21-65 11.10P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 6-05 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1708 E. FAYETTE ST. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | | | |
| | | D. STREET ADDRESS (If rural, give location) 1708 E. FAYETTE ST. | | | |
| 5. SEX F | 6. RACE C. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH Aug. 7. 1898 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURRIER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N.C. | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME BROWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-87-1440 | | 17. INFORMANT WALTER QUEEN | |
| 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH A. Cardio-Vascular Disease DUE TO B. DUE TO C. DUE TO | | INTERVAL BETWEEN ONSET AND DEATH ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 13 1965 to Dec. 21 1965, that (I) (we) last saw the deceased alive on Dec. 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bernard Harris M.D. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) Bernard Harris Sr | | 23D. ADDRESS M.D. 1202 N Caroline St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12/26/65 | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pl. | | 24D. LOCATION (City, town, or county) (State) ARbutus, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR R. L. 2, Jr. | | 25C. FUNERAL DIRECTOR J. L. Rock Jr. | |
| | | | | ADDRESS 1304 N. Central | |

| BIRTH NO. 65 13168 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13168 | |
|---|------------------|---|--|--|---|
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) LILA PEACH | | | 2. DATE AND HOUR PRONOUNCED DEAD December 23, 1965 2:30 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 8-04 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) PARK 1233 N. Patterson Avenue | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH Aug 22, 1898 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Wilson Shorter | | 14. MOTHER'S MAIDEN NAME Olivia Powell | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 219-01-6052 | 17. INFORMANT ADDRESS Jada Fuller 1704 N. Bradford | | |
| 18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease. INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/23/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 12/27/65 | 23C. NAME OF CEMETERY or CREMATORY Lanham Chapel | | 23D. LOCATION (City, town, or county) (State) Sparks, Md |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 24B. NAME OF REGISTRAR R. E. Jenkins | | 24C. FUNERAL DIRECTOR ADDRESS Joseph S. Rocks 1304 N. Central | |

VALLEY FOLIO

PAID CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| BIRTH NO. 65 28591 | | 65 13169 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13169 | | 4 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) PAULA BROWN | | 2. DATE AND HOUR OF DEATH 12/23/65 3:05 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital of Baltimore | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3907 Haywood Ave 27-18 | | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never | | 8. DATE OF BIRTH 11-16-65 | | 9. AGE (In years last birthday) 1 7 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME PAUL BROWN | | | | 14. MOTHER'S MAIDEN NAME Paula Whitcomb | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT parents | | ADDRESS Same | |
| 18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Possible Bronchopneumonia DUE TO (B) DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (if this hospital) attended the deceased from 11/16/65 to Dec. 23 19 65, that (if we) last saw the deceased alive on 12/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Barbara C. Wagner M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/23/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) BARBARA C. WAGNER | | | | 23D. ADDRESS Sinai Hospital of BALT. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/27/65 | | 24C. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist Cem. Reisterstown, Md | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR C. V. Zimmern | | ADDRESS 4611 Park Heights | | | |



For the purpose of the present investigation, the
data were collected from the following sources:

F-622

65 13170

BALTIMORE CITY HEALTH DEPARTMENT

65 13170

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____
 M.E. CASE NO. _____
 1. NAME OF DECEASED (Type or Print) JESSE FORYSIAK
CESLAUS FORYSIAK
 2. DATE AND HOUR PRONOUNCED DEAD
 December 23, 1965 8:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Baltimore City Hospitals
 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
 A. STATE Maryland B. COUNTY _____
 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 1-01
 D. STREET ADDRESS (If rural, give location)
717 S. Decker Avenue

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED 8. DATE OF BIRTH 9-13-1903 9. AGE (In years last birthday) 62
 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LONG SHORMAN 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country)
MARYLAND 12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME THOMAS FORYSIAK 14. MOTHER'S MAIDEN NAME FRANCES PAWLOWSKA
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO.
215-05-0443 17. INFORMANT HELEN FORYSIAK ADDRESS _____

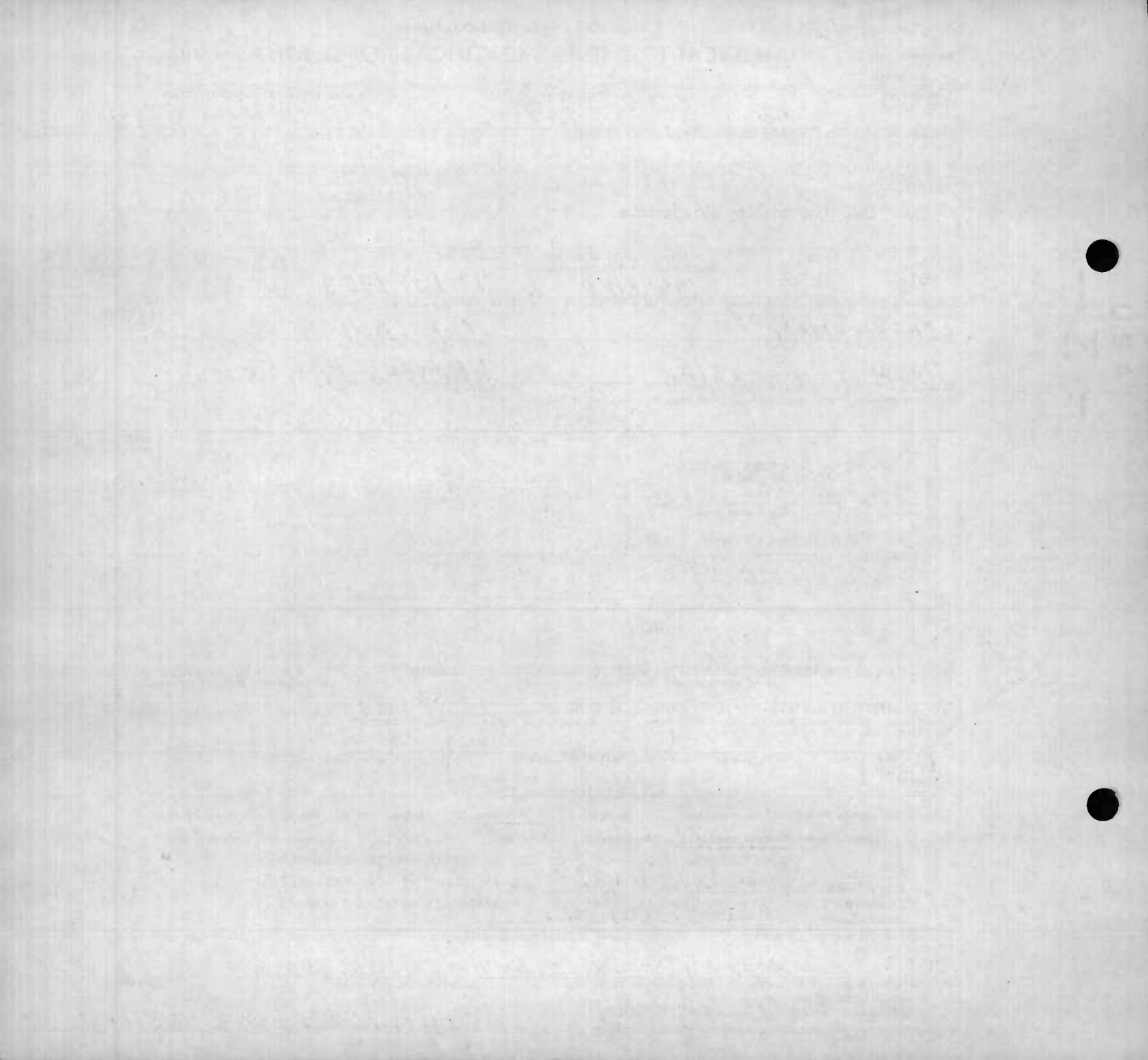
18. 422.1 I CAUSE OF DEATH
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardiovascular Disease.
 (A) DUE TO _____
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
 (B) DUE TO _____
 (C) _____
 II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No)
Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
 ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER ☐
 EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 12/23/65

23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL 23B. DATE 12-27-1965 23C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEM. 23D. LOCATION (City, town, or county) (State)
DUNDALK MD
 24A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 24B. NAME OF REGISTRAR John M. Weber 24C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC. ADDRESS 4015 CHESTER ST



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------|--|--------------------------|---|---|
| BIRTH NO. 65 13171 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13171 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WISNIEWSKI, Ellg (Brown) | | 2. DATE AND HOUR OF DEATH 12/21/65 12:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | MARYLAND BALTIMORE CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 7216 EASTERN AVENUE #21224 | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3-26-11 | 9. AGE (In years lost birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ? DEIER | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. 422.1 IV 170X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO Cardiac arrest (B) DUE TO diabetic acidosis (C) DUE TO ASCVD | | INTERVAL BETWEEN ONSET AND DEATH 2 wks years | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Ca breast | | 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12/19/65 to 12/21/65, that (II) (we) last saw the deceased alive on 12/21/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Harry Dean Albert | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. HARRY DEAN ALBERT | | 23D. ADDRESS 4940 EASTERN AVENUE #21224 | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | |
| 24B. DATE 12-24-1965 | | 24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEM | | 24D. LOCATION (City, town, or county) DUNDALK MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR John M. Weber | | 25C. FUNERAL DIRECTOR ADDRESS JOHN M. WEBER & SONS INC 4015 CHESTER ST | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13172 | |
|--|-------------------------|---|------------------------------------|--|--|
| BIRTH NO. 65 13172 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FRIERS, LULA MAY | | 2. DATE AND HOUR OF DEATH 12-23-65 6:30A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 07 53-00 D. STREET ADDRESS (If rural, give location) 1112 LANDINGTON ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED MARRIED | 8. DATE OF BIRTH 5-10-84 | 9. AGE (In years lost birthday) 81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GEORGE FRIES | | | |
| 14. MOTHER'S MAIDEN NAME MINNIE BOCKELMAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) *** | | | |
| 16. SOCIAL SECURITY NO. NO | | 17. INFORMANT ADDRESS ST. AGNES RECORDS -CATON & WILKENS AVE | | | |
| 18. 443 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERA - Cerebral Hemorrhage | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO HASCVD | | INTERVAL BETWEEN ONSET AND DEATH 16 hours Unknown | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 22 1965 to DECEMBER 23 1965 , that (I) (we) last saw the deceased alive on DECEMBER 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. Gallager, Jr. | | | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) W. GALLAGER, JR. | | 23D. ADDRESS 6630 BALTO NAT'L PIKE #28 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS John T. Thompson 6411 Windsor Hill Rd. | | | |

DATE: 12-1-77

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

[Large block of illegible text, likely a body paragraph or list of items]

DECEMBER 1, 1977

NEW YORK

RECEIVED

12-1-77

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

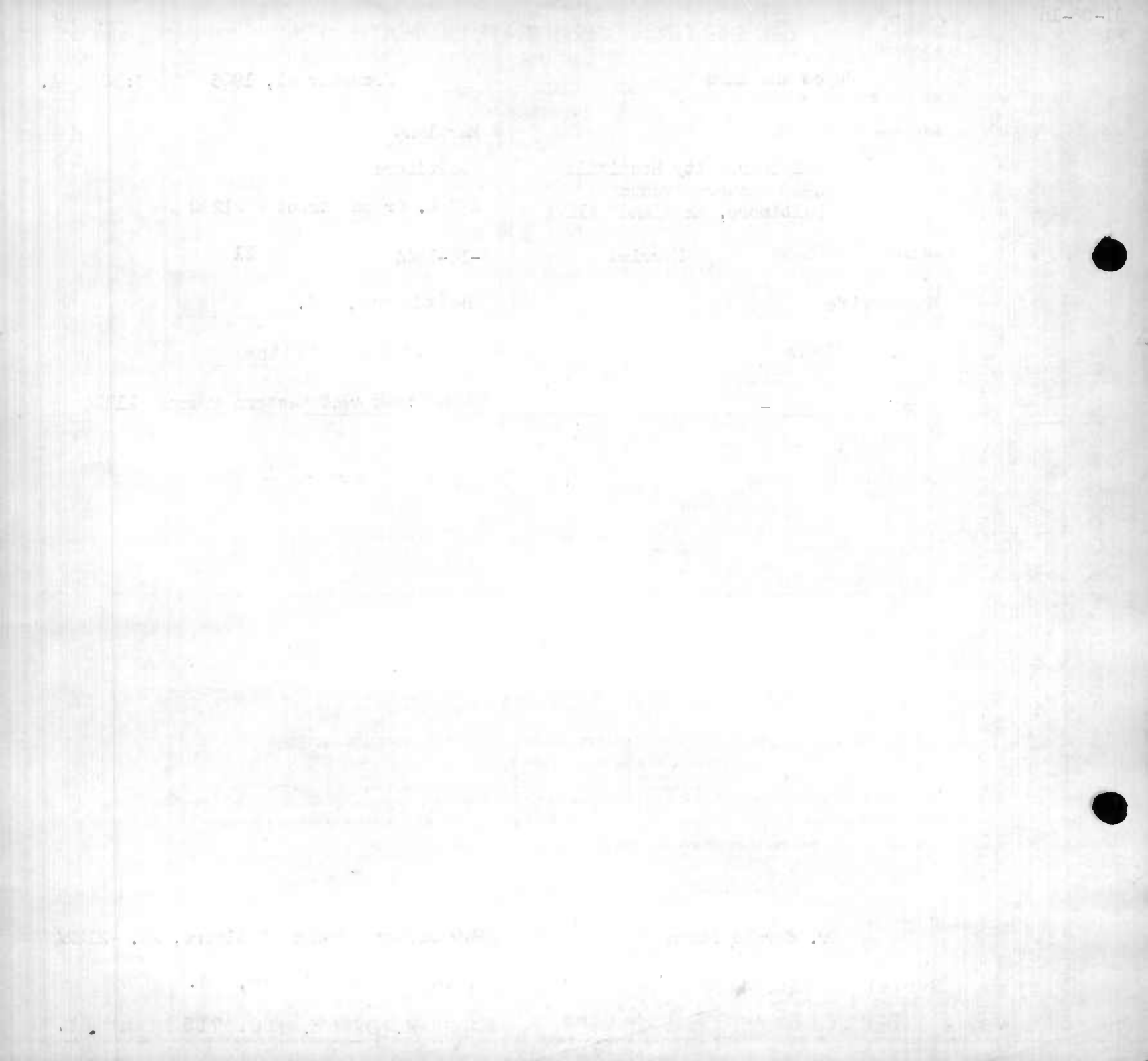
NY 100-100000

31-06-16
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 13173 | |
|---|------------------|--|-------------------------------|--|--|
| K-650 65 13173 | | BIRTH NO. | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Joyce Ann Karn | | December 21, 1965 3:30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 432 E. Cross Street 21230 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5-16-1944 | 9. AGE (In years last birthday) 21 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME Leon Hicks | | 14. MOTHER'S MAIDEN NAME Alpha Phillips | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO Hodgkins Disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | DUE TO | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 19 65 to Dec 21 19 65, that (I) (we) last saw the deceased alive on Dec 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Gerald Posen | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec 21/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Gerald Posen | | 23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/65 | | 24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR John F. Denny, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 Light St. | |



65 13174

BALTIMORE CITY HEALTH DEPARTMENT

65 13174

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WARREN George Rauschkolb

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1965 3:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 Poultney Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

44 Poultney Street

23-02

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

- 1921

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

433 18 3499

17. INFORMANT

Cpt. Cortland Moore

ADDRESS

Salvation Army
1021 Light St.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/17/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 27 1965

24B. NAME OF REGISTRAR

Robert E. Galt

24C. FUNERAL DIRECTOR

JOHN F. DENNY, INC. 715 Light St.

ADDRESS

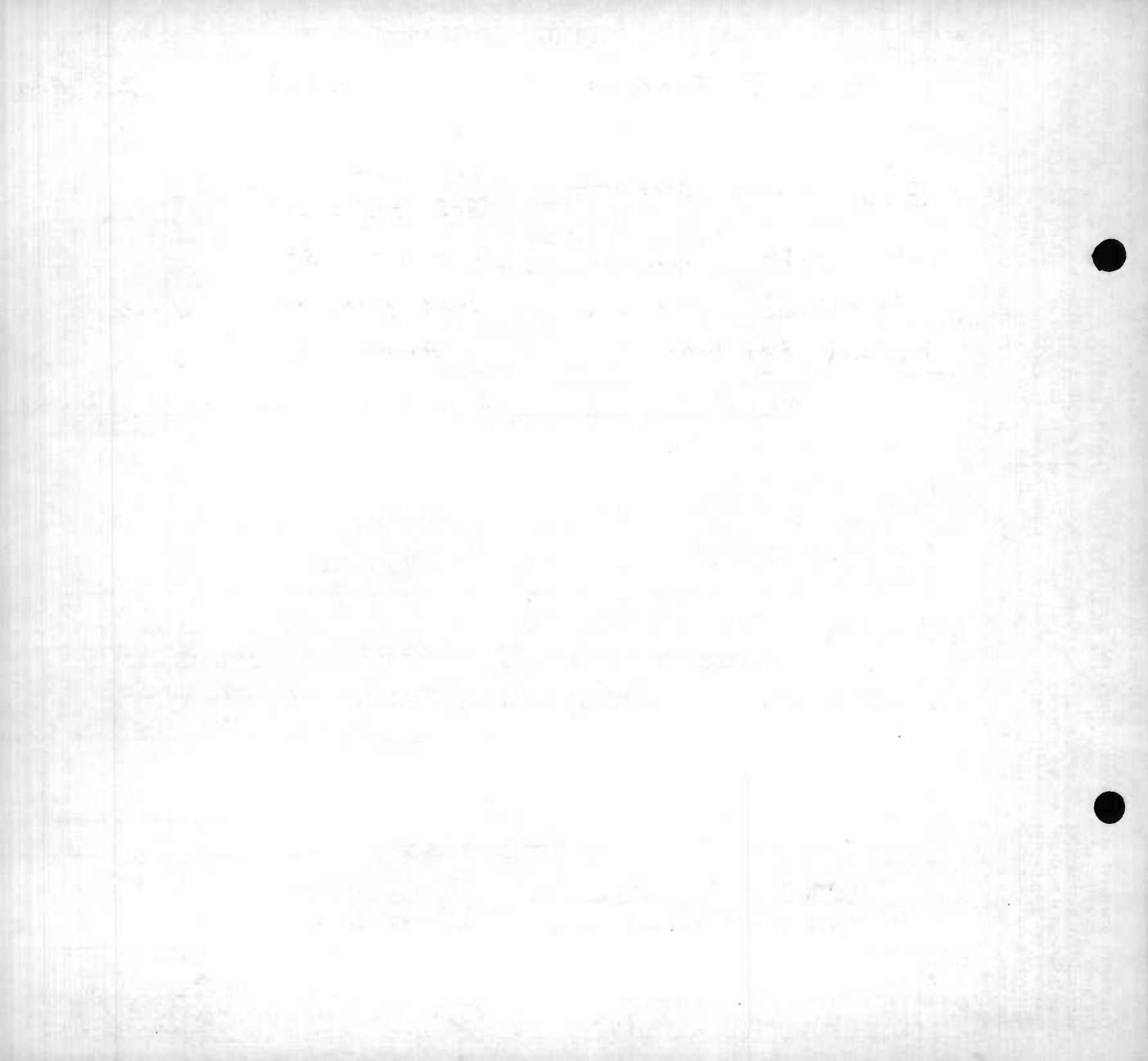
WALLEY RIDGE

WALLEY RIDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

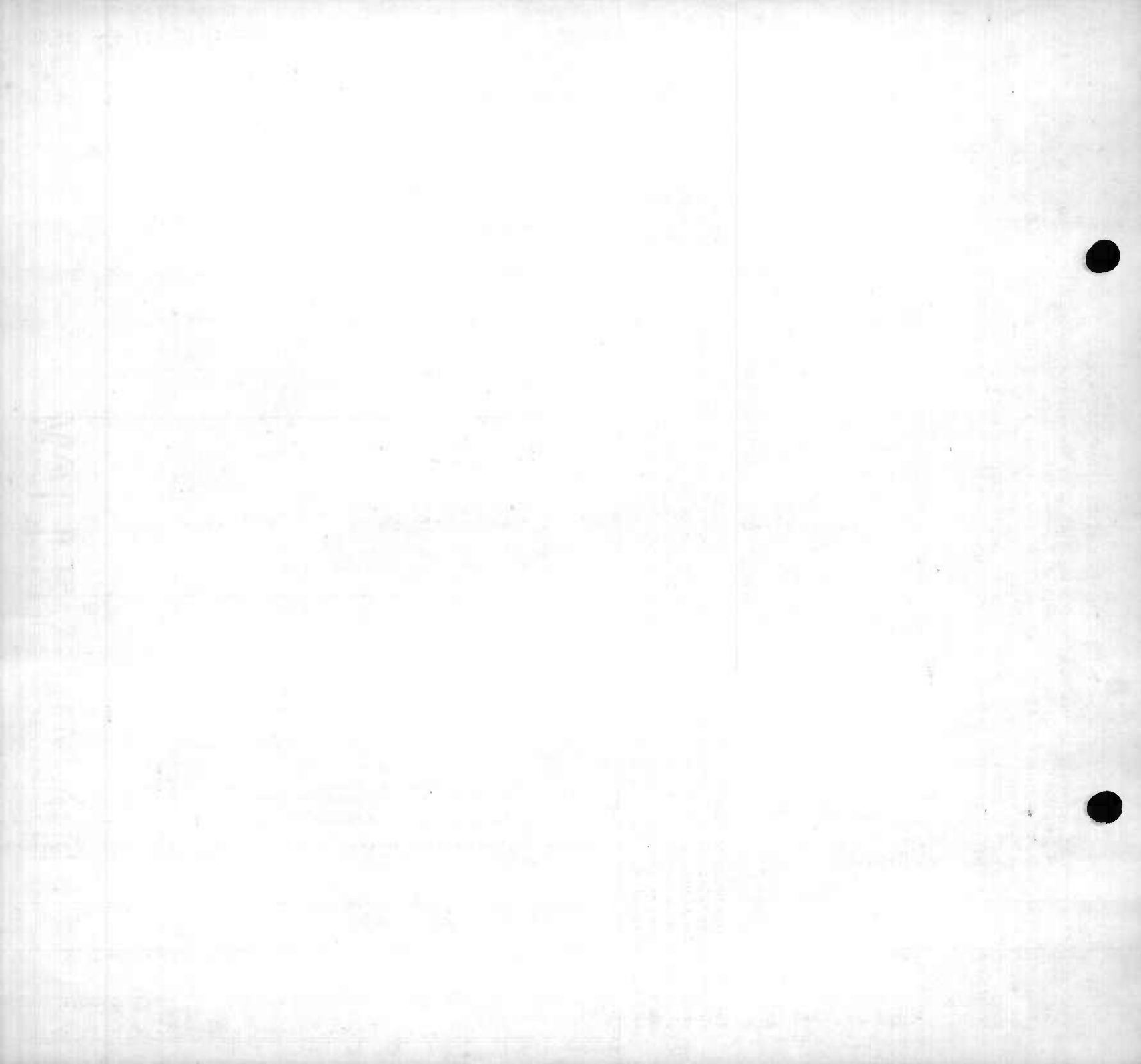
| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 65 13175 | | 65 13175 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Paul F. Zapresko | | | | 12/23/65 | | 7:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | |
| Bon Secours Hospital | | | | Md. | | 18-03 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| 5. SEX | | | | 6. DATE OF BIRTH | | 9. AGE (In years lost birthday) | |
| male | | white | | 2-20-1912 | | 53 | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | If Under 1 Yr. Months Days | |
| Divorced | | 2-20-1912 | | 53 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Chauffeur | | TAXICAB | | Baltimore, Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Michael Zapresko | | | | Anna STEFFENIE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | NONE | | James Zapresko 4436 Cedar Garden Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I | | | | C.A. of lung. | | years. | |
| ANTECEDENT CAUSES | | | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| II | | | | (C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 17 19 65 to Dec. 23 19 65, that (I) (we) last saw the deceased alive on Dec. 23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Jose V. de Leon, Jr. | | | | Dec. 23, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| JOSE V. DE LEON, JR. | | | | BON SECOURS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 12-27-65 | | New Cathedral | | BALTIMORE, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 27 1965 | | R. E. J. J. J. | | Geo. L. Schwab Funeral Home | | 2101 Frederick Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------|--|---|---|---|
| BIRTH NO. 65 13176 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 13176 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) ROBERT SEITZ | | |
| 2. DATE AND HOUR OF DEATH 12-23-65 2:10 A.M. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | D. STREET ADDRESS (If rural, give location) 4101 ANNAPOLIS RD. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-10-13 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Em p. | | 10B. KIND OF BUSINESS OR INDUSTRY Trucking Co. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME ADAM SEITZ | | |
| 14. MOTHER'S MAIDEN NAME MARGARET WALTERS | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 215-01-1754 | | | 17. INFORMANT DOLORE S SEITZ ADDRESS 4101 ANNAPOLIS RD BALTO, MARYLAND, 21 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MEDICASTMIS | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-21-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA ESOPHAGUS | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? Baltimore City, give exact location | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 12 1965 to DECEMBER 23 1965, that (I) (we) lost saw the deceased alive on DECEMBER 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rosario D. Bello | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) ROSARIO D. BELLO | | | 23D. ADDRESS MARYLAND GENERAL HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-27-65 | | 24C. NAME OF CEMETERY OR CREMATORY New Cath. | |
| 24D. LOCATION (City, town, or county) Balto 29 | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR McCully J. ... ADDRESS 237 Outspace Ave ... | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 13177 | |
|---|-----------|---|--------------------------|--|--|
| BIRTH NO. 65 13177 | | CERTIFICATE AMENDED | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CLETIS BLANKENSHIP | | 2. DATE AND HOUR OF DEATH 12/25/65 7:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY B. Prince | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) CAPITOL HEIGHTS 6005 HST | | | |
| | | D. STREET ADDRESS (If rural, give location) 6005 8th ST NE 66-00 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NMARRIED | 8. DATE OF BIRTH 7/27/52 | 9. AGE (In years lost birthday) 13 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | |
| 13. FATHER'S NAME THOMAS BLANKENSHIP | | 14. MOTHER'S MAIDEN NAME PAULINE FLOOT | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE NONE | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT PAULINE BLANKENSHIP C+D | |
| 18. 401.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) PULMONARY INFARCTION | | | |
| ANTECEDENT CAUSES | | (B) PULMONARY EMBOLI | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (C) Acute RHEUMATIC FEVER & CARDITIS | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | film 629 7/6/87 cms item #14 | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/14 19 65 to 12/22 19 65, that (I) (we) last saw the deceased alive on 12/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE BA BRIAN | | | | 23B. DATE SIGNED 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) BA BRIAN | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/26/65 | | 24C. NAME OF CEMETERY or CREMATORY MOCCASING CEMETERY MUDFORK W. VA. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |

UNIVERSITY HOSPITAL
M W M

CHARTER HEIGHTS
POOZ 24 ME
1/2/22

THOMAS BANKERSHIP

FORWARD Y. GANESAN
FORWARD Y. GANESAN
FORWARD Y. GANESAN
FORWARD Y. GANESAN

1/2/22 20 1/2/22 1/2/22

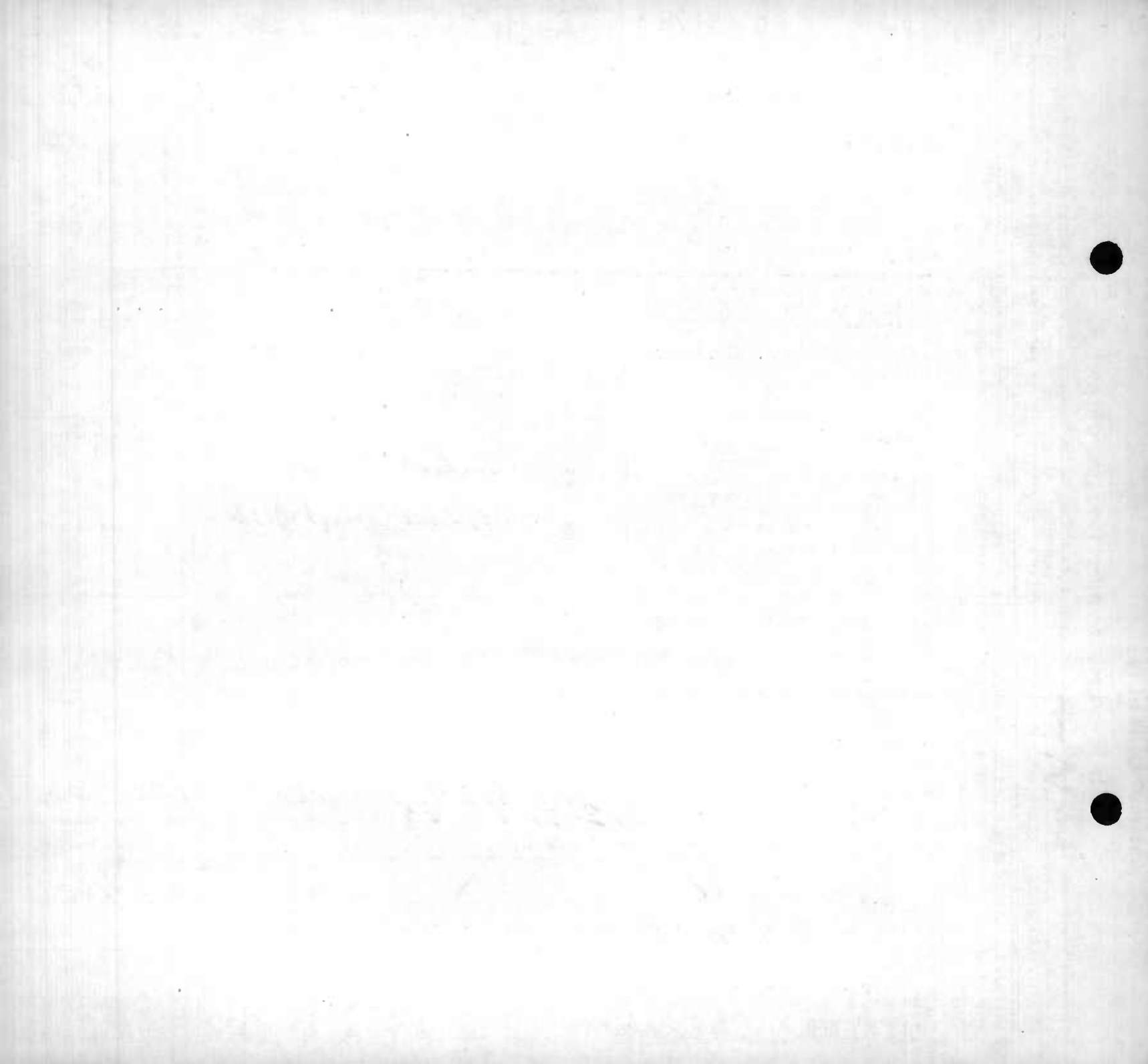
UNIVERSITY HOSPITAL

THOMAS BANKERSHIP

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

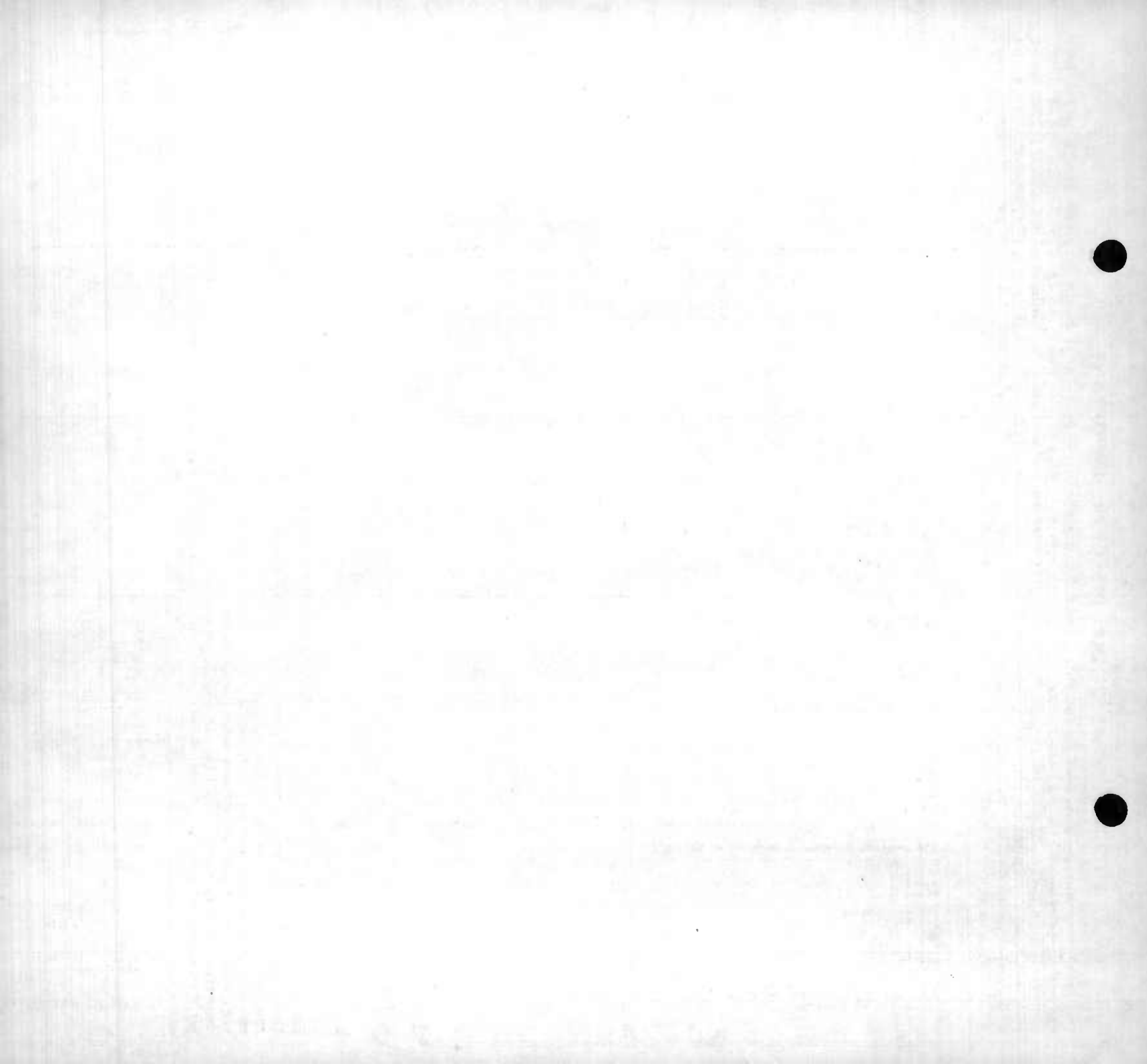
| | | | | | |
|--|------------------|--|--|---|--|
| BIRTH NO. 65 13178 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13178 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Harry A. Weilbrenner | | | 2. DATE AND HOUR OF DEATH 12- 24-1965 12 ⁰⁰ M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2-6-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4217 Berger Avenue #6 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-20-1905 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) National Brewery | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME John A. Weilbrenner | | |
| 14. MOTHER'S MAIDEN NAME Minnie Ashauer | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 213-01-8815 | | | 17. INFORMANT Mrs Ruth E. Weilbrenner 4217 Berger A | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Cardiac Arrest (B) DUE TO Ischemic Heart Disease (C) _____ INTERVAL BETWEEN ONSET AND DEATH | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/24/65 1962 to 12/24 1965, that (I) (we) last saw the deceased alive on 12/21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A.M. Renick | | | 23B. DATE SIGNED 12/24/65 | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) A.M. Renick | | | 23D. ADDRESS 1010 St. Paul | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-27-1965 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | |
| 25B. NAME OF REGISTRAR R. E. Jenkins | | 25C. FUNERAL DIRECTOR L. J. Jenkins | | | |
| 25D. ADDRESS (36) 7401 Belair Road | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13179 | |
|---|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 65 13179 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) KLISZES ANTONINE | | 2. DATE AND HOUR OF DEATH 12-23-1965 12²⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland B. COUNTY 12-02 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 3221 St. Paul St. 21218 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 5-20-89 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing Co. | | 11. BIRTHPLACE (State or foreign country) Lithuania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Matthew Kliszes | | 14. MOTHER'S MAIDEN NAME EVA Guodisius | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Dr. Jelle Loubertis - 812 Hollins St. - ① | |
| 18. 460X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Congestive Heart failure (Post operative) (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12-21-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Varicose Vein & Varicose ulcer | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12-11-1965 to 12-23-1965 , that (I) (we) last saw the deceased alive on 12-23-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Nabil F. Warsal | | | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) NABIL F. WARSAL | | 23D. ADDRESS University Hosp - Balt. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12/27/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | |
| 25B. NAME OF REGISTRAR John J. ... | | 25C. FUNERAL DIRECTOR ADDRESS John J. ... 901 Hollins St. Baltimore, Md. | | | |



65 13180

BALTIMORE CITY HEALTH DEPARTMENT

65 13180

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AARON FRANK CHARLES

2. DATE AND HOUR PRONOUNCED DEAD

24 December 1965 8:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

56 Talbot St.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 23, 1894

9. AGE (In years
last birthday)

68 7/8

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired B&O

10B. KIND OF BUSINESS OR INDUSTRY

Telegrapher

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frank Charles

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown); (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Andrew Norbeck 76 Cameron Rd. Hunt Valley Pa

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/25/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/29/65

23C. NAME of CEMETERY or CREMATORY

Sunset Mem. Park Cem.

23D. LOCATION (City, town, or county)

Phila. Penna.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 27 1965

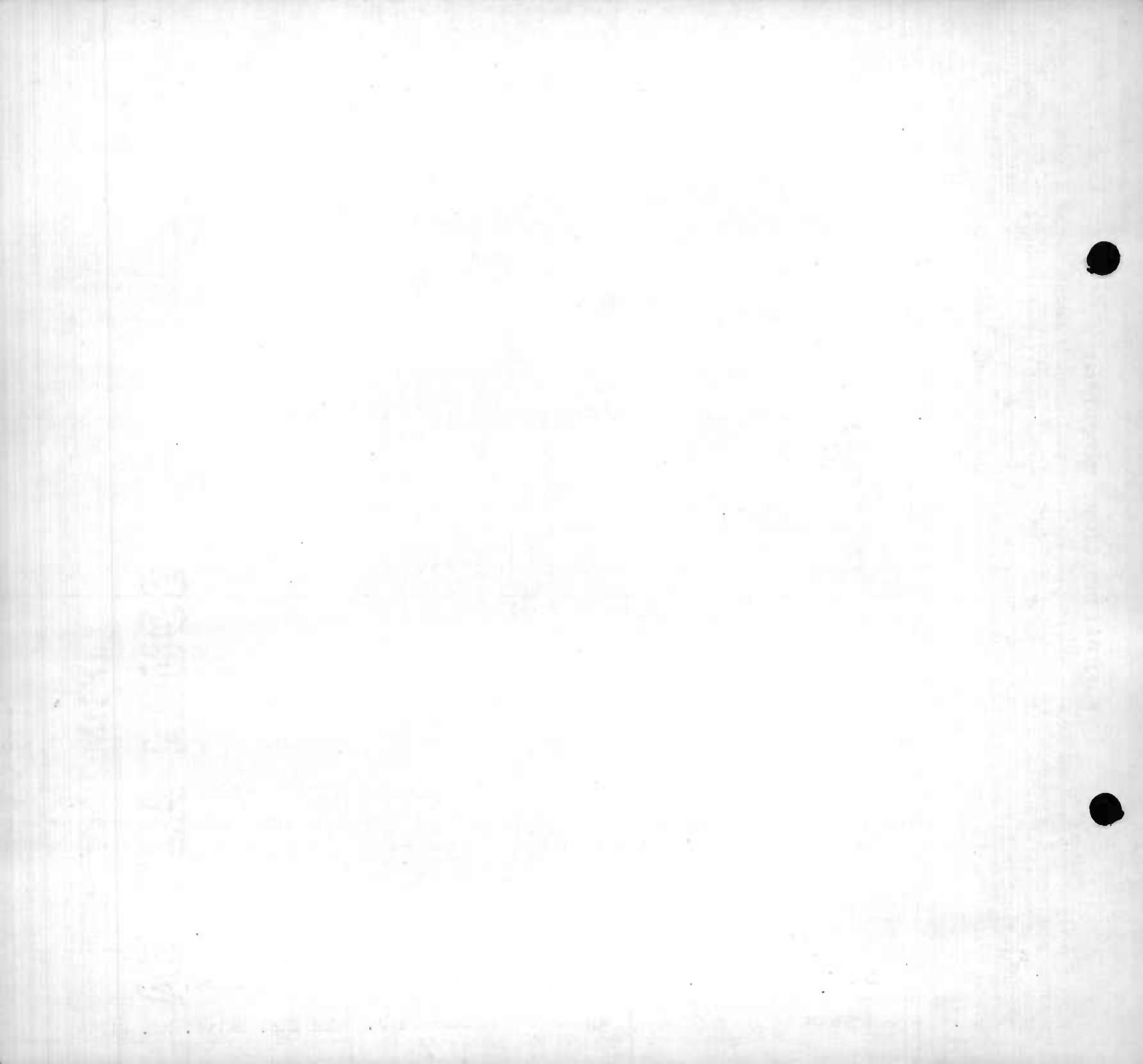
McCully Funeral Home 237 Patapsco Ave.

12 VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Baltimore City Health Department | |
|--|--|---|--|---|--|
| BIRTH NO. | | 65 13181 | | Registered No. 65 13181 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | MAR ROSE (MAY) TINGLEY | | DECEMBER 22/1965 1:00A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| 36 FRANKLIN SQUARE HOSPITAL 100 N. CALHOUN ST. # 23 | | | | MARYLAND 8-01 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | BALTIMORE 21213 | |
| D. STREET ADDRESS (If rural, give location) | | | | 2900 CLIFTON PARK TERRACE | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| FEMALE | | WHITE | | WIDOW | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| HOUSEWIFE & CROSSING GUARD | | Own Home | | MAY 19, 1909 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| ALBERT A. WINKLER | | CLARA | | 56 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 213-34-1216 | | ROSE K. PETZOLD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | ADDRESS | |
| 410X I | | SUBACUTE BACTERIAL | | 5619 BELLE VISTA AVE. # | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | DUE TO | | 715 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | DUE TO | | SINCE | |
| II | | DUE TO | | CHILDHOOD | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | DUE TO | | TO RHEUMATIC HEART DISEASE | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 7, 1965 to December 22, 1965, that (I) (we) last saw the deceased alive on December 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Quintin L. Hyatt | | | | December 22, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| QUINTIN L. HYATT | | | | FRANKLIN SQUARE HOSPITAL | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/24/65. | | Parkwood Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 27 1965 | | Leonard J. Ruck Inc. | | ADDRESS | |
| 25D. LOCATION (City, town, or county) (State) | | 25E. ADDRESS | | 25F. ADDRESS | |
| Baltimore, Md. | | Leonard J. Ruck Inc. Balto. Md. 21214 | | 21214 | |



FUNERAL DIRECTOR: IMPORTANT

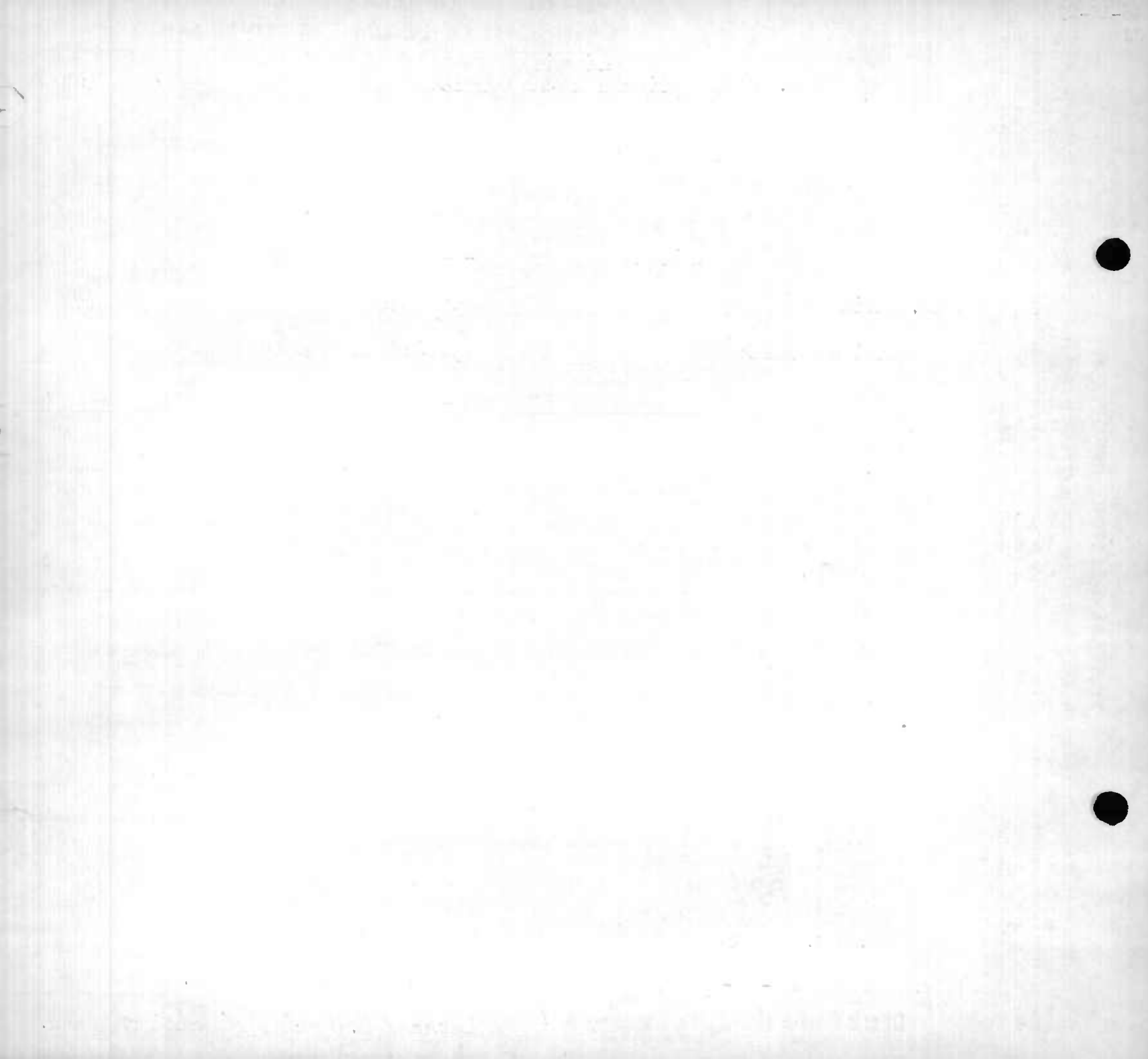
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 13182</u> | |
|--|------------------------------|--|------------------------------------|---|--|
| BIRTH NO. <u>65 13182</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Barbara C. Lovell</u> | | 2. DATE AND HOUR OF DEATH <u>3³⁰ AM</u> <u>12/23/65</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-09</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> | | D. STREET ADDRESS (If rural, give location) <u>1507 Hockwood Rd.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>10/5/42</u> | 9. AGE (In years last birthday) <u>23</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>William Francis Caldwell</u> | | 14. MOTHER'S MAIDEN NAME <u>Gretchen Gibbons</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-40-7671</u> | | 17. INFORMANT ADDRESS <u>Mr. Robert M. Lovell (Same)</u> | |
| 18. <u>648.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism, Atherosclerosis & Congestive Heart Failure</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <u>Fetus death</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1.30 hr</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>12/22/1965</u> to <u>12/22/1965</u> , that (I) <u>we</u> last saw the deceased alive on <u>3³⁰ a.m. 12/22 1965</u> and that in my <u>(aur)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>F. Malek</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/22/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>FREIDOUN MALEK M.D.</u> | | 23D. ADDRESS <u>MERCY HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12/24/65</u> | 24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D. BY HEALTH DEPT. <u>DEC 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. ...</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. Md. 21214</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|----------------------------|---|--|
| BIRTH NO. 65 13183 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65-13183 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) (Lizzie) (MARY E. LAUER) Elizabeth Mary Lauer | | 2. DATE AND HOUR OF DEATH 12/21/65 4:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3501 BERWYN AVE. | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH 9-2-72 | 9. AGE (In years lost birthday) 93 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Maid | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Simon Lauer | | 14. MOTHER'S MAIDEN NAME Christina Wuertz | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BCH - RECORDS - 4940 EASTERN AVENUE #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of Breast. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH Unknown. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASHD | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-9-65 to 12-21-65, that (I) (we) last saw the deceased alive on 12-21-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Patrick Caulfield | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. J. PATRICK CAULFIELD | | 23D. ADDRESS 4940 EASTERN AVENUE #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc | |
| 25D. ADDRESS Baltimore, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13184 | | CERTIFICATE OF DEATH | | Registered No. 65 13184 | |
|--|-------------------------|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JACKSON, ADOLPHUS | | | | 2. DATE AND HOUR OF DEATH DEC 23, 1965 7:20 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 25-33 D. STREET ADDRESS (If rural, give location) 2415 S. PACA STREET 21230 | | | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | | 8. DATE OF BIRTH 9-29-13 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BETHLEHAM STEEL | | | | 10B. KIND OF BUSINESS OR INDUSTRY STEEL | | 11. BIRTHPLACE (State or foreign country) GEORGIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE JACKSON | | | | 14. MOTHER'S MAIDEN NAME ADA KING | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | | | 16. SOCIAL SECURITY NO. 410-18-0544 | | 17. INFORMANT PATIENT | | ADDRESS ✓ | |
| 18. 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) BRONCHOGENIC OAT CELL CARCINOMA OF LEFT LUNG | | | | CAUSE OF DEATH (A) BRONCHOGENIC OAT CELL CARCINOMA OF LEFT LUNG (B) SECONDARY METASTASIS TO REGIONAL LYMPH NODES + BRAIN (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 8 mo. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | | | |
| 19A. DATE OF OPERATION 9-1-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BIOPSY LYMPH NODE | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from NOV. 30 1965 to DEC 23 1965 , that (I) (we) last saw the deceased alive on DEC 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Charles S. Harrison | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-23-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Charles S. Harrison | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/29/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR Charles A. Rice | | ADDRESS 6614 Barrest | | | |

DAVIDSON, ALAN

UNIVERSITY OF MICHIGAN
MADE IN THE U.S.A.
JAN 1964

BETWEEN 1964 AND 1965
GEORGE C. DAVIDSON
ALAN DAVIDSON
UNIVERSITY OF MICHIGAN

DAVIDSON, ALAN
UNIVERSITY OF MICHIGAN
JAN 1964

DAVIDSON, ALAN
UNIVERSITY OF MICHIGAN
JAN 1964

DAVIDSON, ALAN
UNIVERSITY OF MICHIGAN
JAN 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|----------------------|--|---|--|--|
| BIRTH NO. 65 13185 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13185 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) <i>Maggie Mahone</i> | | |
| 2. DATE AND HOUR OF DEATH <i>12-22-65 11:20 A.M.</i> | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>19-03</i> | | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | |
| 6. STREET ADDRESS (If rural, give location) <i>217 S Parist St. PARRISH</i> | | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bar-Wit-Ba Convalescent Home</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>11-1876</i> | 9. AGE (In years last birthday) <i>89</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>W.V.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>UNKNOWN</i> | 17. INFORMANT ADDRESS | | |
| 18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Arteriosclerotic heart disease</i> DUE TO (B) <i>Generalized arteriosclerosis</i> DUE TO (C) | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-11-1965</i> to <i>12-22-1965</i> that (I) (we) last saw the deceased alive on <i>12-20-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>C.R. Campbell</i> | | | | 23B. DATE SIGNED <i>2-12-17</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>C.R. Campbell</i> | | 23D. ADDRESS <i>1618 W. North Ave. Baltimore, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Int. Calvary</i> | | 24D. LOCATION (City, town, or county) (State) <i>Brooklyn, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Ed. J. ...</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Charles A. Rice, 661 W. Barre St</i> | |

Female Negro
By Will-Bu Convallescent House

Ammoniochloride 1/2 T. 3 times
Glycerin 1/2 T. 3 times

No

17-11-11

17-11-11

Dr. Campbell
C. Campbell

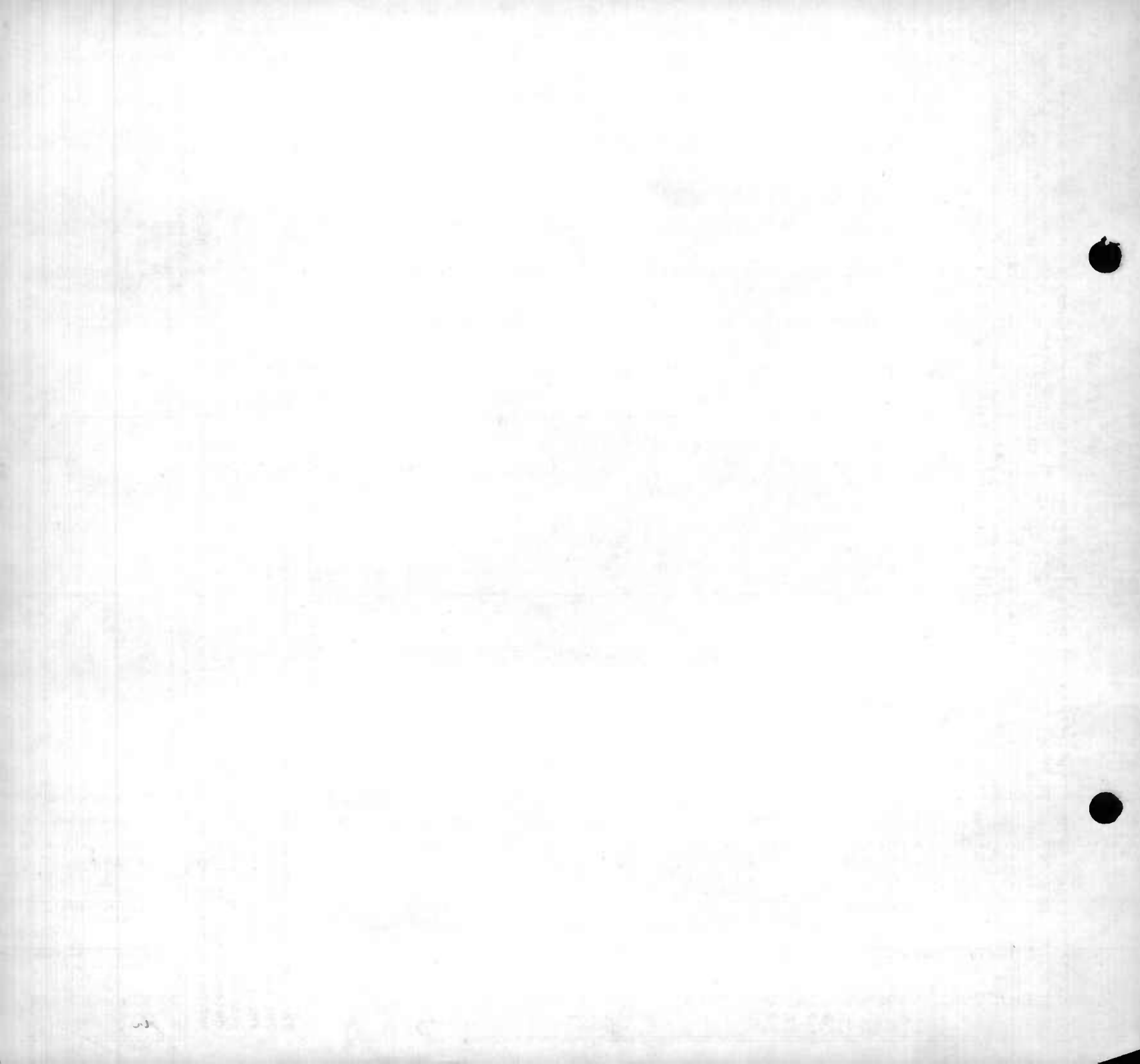
210-11

1000 North Ave. Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------|---|------------------------------------|--|---|
| BIRTH NO. 65 13186 | | CERTIFICATE OF DEATH | | Registered No. 65 13186 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ELIZABETH SINIS | | 2. DATE AND HOUR OF DEATH 12-24-65 245 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 18-1 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSP | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 829 W. Fayette ST. | |
| 5. SEX ♀ | 6. RACE NEG | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2-25-06 | 9. AGE (In years lost birthday) 59 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N CAR | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Clinical Record Briefer Univ Hosp | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X 1-171X | | CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) Hypertension DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ca or Cervix P Irradiation | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-23 19 65 to 12-24 19 65 , that (I) (we) last saw the deceased alive on 12-24 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas B. Groffman | | | | 23B. DATE SIGNED 12-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn | |
| 24D. LOCATION (City, town, or county) (State) Baltimore MD | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Charles A. Rice | |
| 25C. FUNERAL DIRECTOR Charles A. Rice | | 25D. ADDRESS 6610 Barre | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------------------|---|-------------------------------------|---|--|
| BIRTH NO. 65 13187 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13187 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Emma Young | | 2. DATE AND HOUR OF DEATH Dec. 25, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1317 Winchester St. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 16-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1009 N. Arlington Ave | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 3-6-1897 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Joha Bias | | 14. MOTHER'S MAIDEN NAME Susan Starks | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Lillian Jackson ADDRESS 1310 W. L. Fayette H. | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Hypertensive Cardiovascular Disease DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1955 to 12-24-1965 , that (I) (we) last saw the deceased alive on 12-24-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas J. Woodrigger Jr. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) Thomas J. Woodrigger Jr. | | 23D. ADDRESS 703 W. Fayette H. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-29-65 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR Sullivan Funeral Home - N. Arlington Ave ADDRESS 1011-13 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

118 01 372
WHITFIELD, EDNA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 13188

BIRTH NO. 65 13188

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDNA WHITFIELD

2. DATE AND HOUR OF DEATH

12.21.65

8:30P

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1824 E. NORTH AVENUE

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

7-8-02

9. AGE (In years
last birthday)

63

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

GEORGE STEWART

14. MOTHER'S MAIDEN NAME

EMMA

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 445X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Hypertensive Cardiovascular

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Disease

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11.19 19 65 to 12.21 19 65,
that (I) (we) last saw the deceased alive on 12.21 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Herman K. Gold

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

12.21.65

23C. PHYSICIAN'S
NAME (Type)

Herman K. Gold

M.D.

23D. ADDRESS

Johns Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/27/65

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 27 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

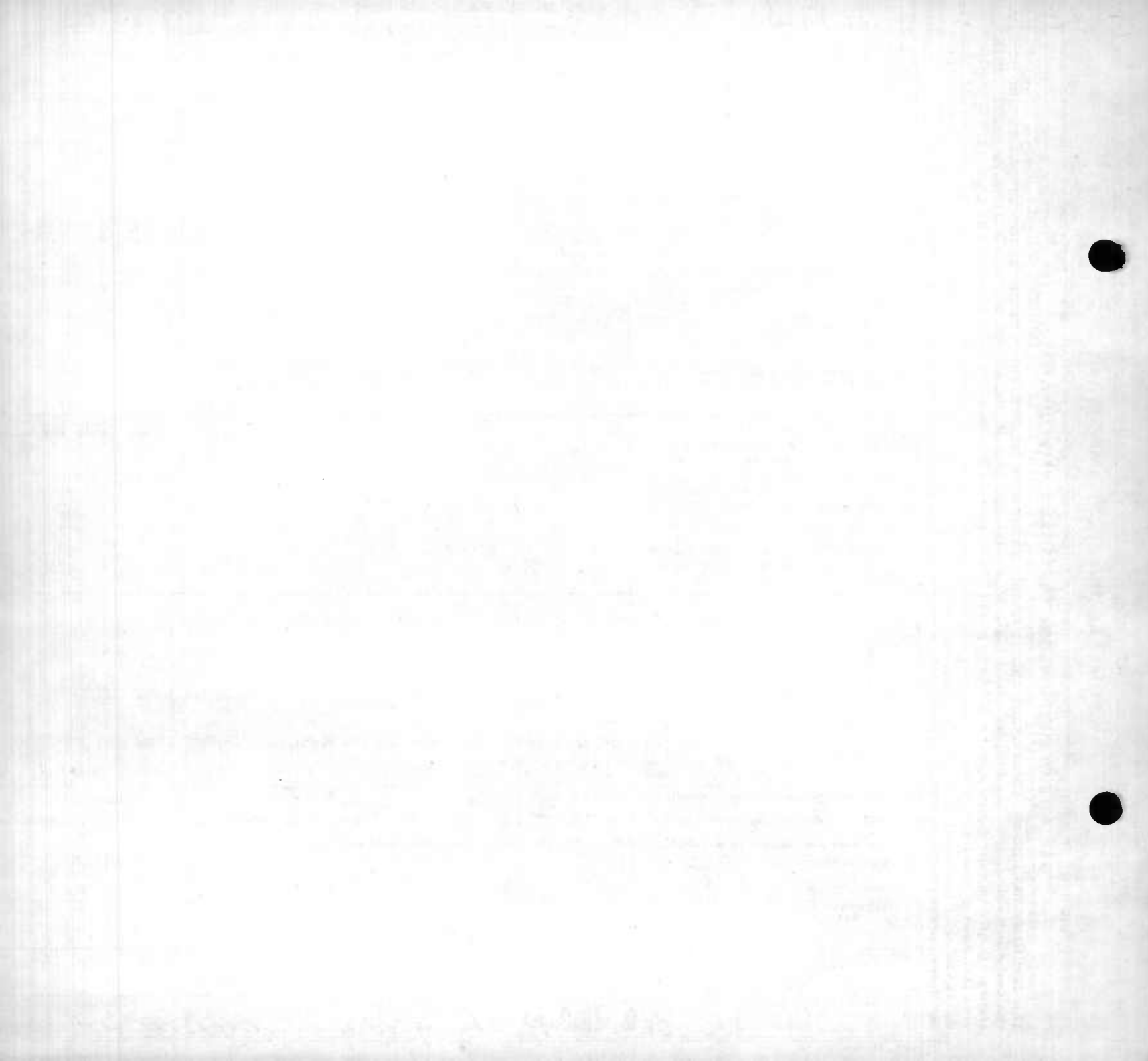
Robert E. Taylor - 1701-03 N. Bond St. City

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

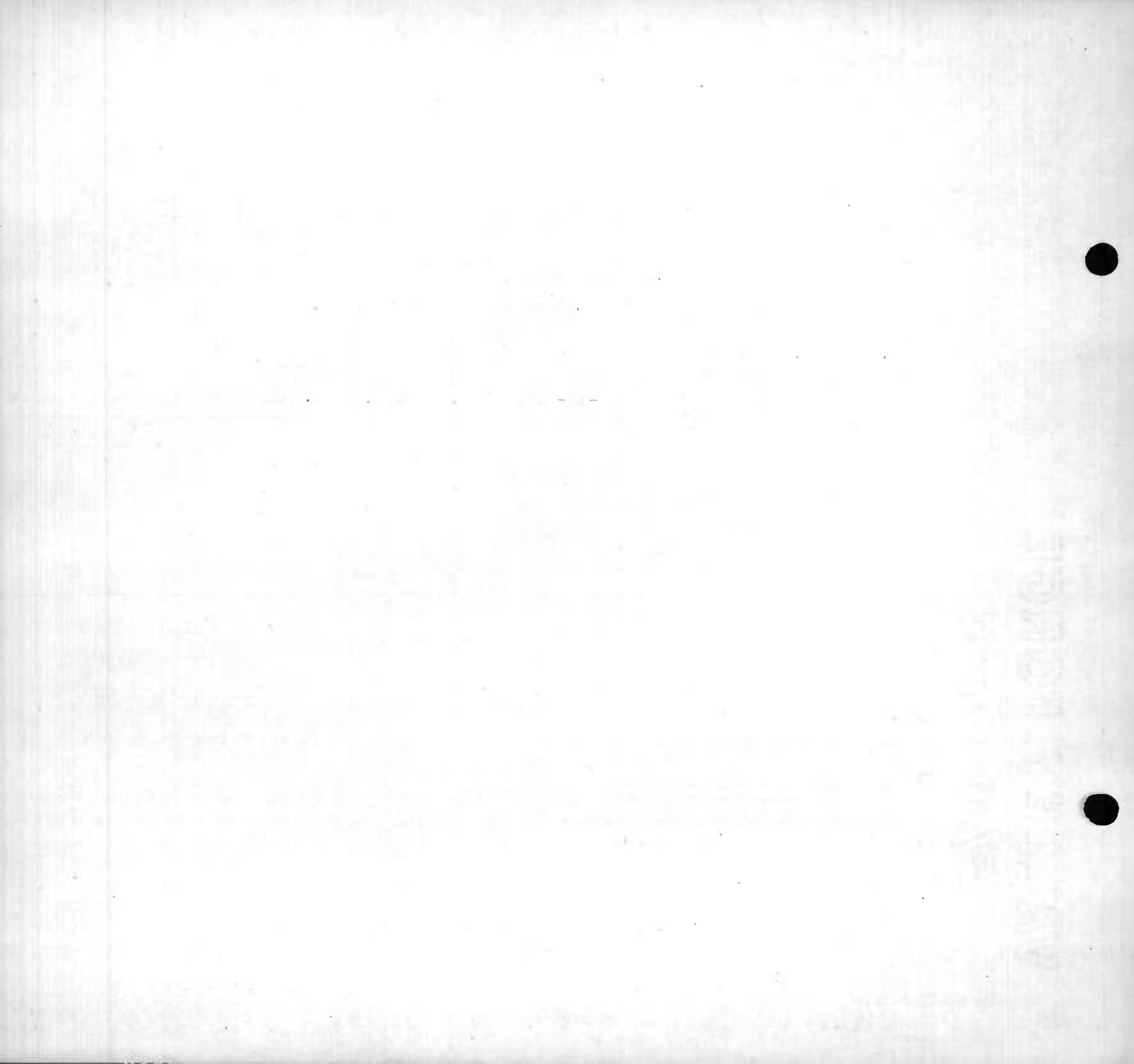
| | | | | | |
|---|---------------------|--|---------------------------------------|---|--|
| BIRTH NO. 65 13189 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13189 | |
| M.E. CASE NO. 319879 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Spencer, Beverly | | 2. DATE AND HOUR OF DEATH 12/22/65 11¹⁰ P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 15-37 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 3301 Patemon Ave. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/20/1914 | 9. AGE (In years last birthday) 60 61 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 331X-181.0 | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) DUE TO CVA | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO Arteriosclerotic cerebral vascular disease | | | |
| ANTECEDENT CAUSES | | (C) DUE TO Chronic | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Ca bladder; ASCVD & CHF | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Pending | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (if this hospital) attended the deceased from 12/27 19 65 to 12/22 19 65 , that (I) (we) last saw the deceased alive on 12/22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Leonard J. Heitzberg M.D. | | Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) Leonard J. Heitzberg | | 23D. ADDRESS Sinai Hospital Balt, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 28, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Not. Calvary Cemetery A.A. Co. Md. | |
| 24D. LOCATION (City, town, or county) (State) Calvary Cemetery A.A. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Williams | |
| 25C. FUNERAL DIRECTOR Robert E. Williams | | ADDRESS 1701-03 N. Bond St. City | | 25D. DATE 21213 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13190 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13190 | |
|---|------------------|---|----------------------------------|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Thomas W. Spicknall | | | | 2. DATE AND HOUR OF DEATH December 25, 1965 6:55 a.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-47 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2103 Dukeland Street 16 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH July 4, 1893 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Belmar Corporation | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Dr. John T. Spicknall | | | | 14. MOTHER'S MAIDEN NAME Emma | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 212-18-3163 | | 17. INFORMANT Mrs. Anna E. Spicknall same address as above | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 6, 1964 to Dec. 25, 1965, that (I) (we) last saw the deceased alive on Dec. 25, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Abraham B. Hurwitz | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec. 27, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ | | | | 23D. ADDRESS M.D. 7501 LIBERTY ROAD, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/1965 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR Wm. J. Spicknall | | 25D. ADDRESS Baltimore, Md. 17 North P. Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

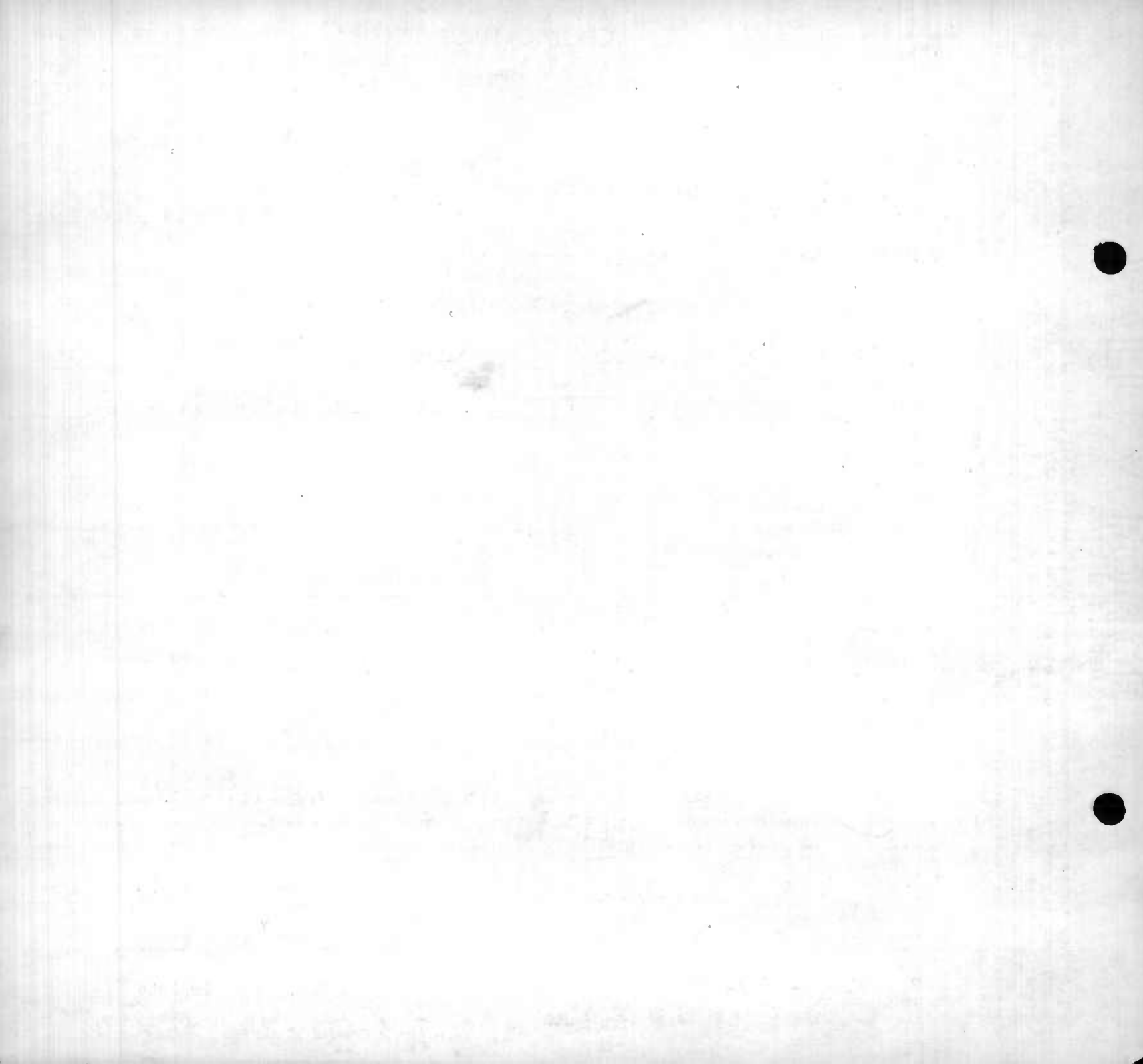
| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. <u>5365 13191</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 13191</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | ENTRIKIN, EDWARD Kerns | | 2. DATE AND HOUR OF DEATH December 22, 1965 7:15 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>OHIO</u> B. COUNTY <u>V-32</u> | | | |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL 1/7/66</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>WOOSTER</u> | | | |
| 5. SEX <u>MALE</u> | | 6. RACE <u>WHITE</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | |
| 8. DATE OF BIRTH <u>7-12-08</u> | | 9. AGE (In years last birthday) <u>57</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - sales Manager</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Lima, Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>JOHN, ENTRIKIN</u> | | 14. MOTHER'S MAIDEN NAME <u>EDITH MENTZER</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>268-16-4480</u> | | 17. INFORMANT <u>Hospital Records</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>E. Coli Septicemia</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Uremia and Diabetes Mellitus</u> DUE TO | | <u>5 years</u> | |
| | | (C) <u>Chronic Gouty Nephritis</u> | | <u>45 years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nolify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>November 18</u> 19 <u>65</u> to <u>December 22</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 22</u> , 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Habert J. Hawick</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/22/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24B. DATE <u>12/23/1965</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Forest Lawn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Youngstown, Ohio</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Wm. J. ...</u> | | 25C. FUNERAL DIRECTOR <u>Wm. J. ...</u> | |
| 25D. ADDRESS <u>Baltimore, Md. 17</u> | | | | | |

vs 153 C. B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

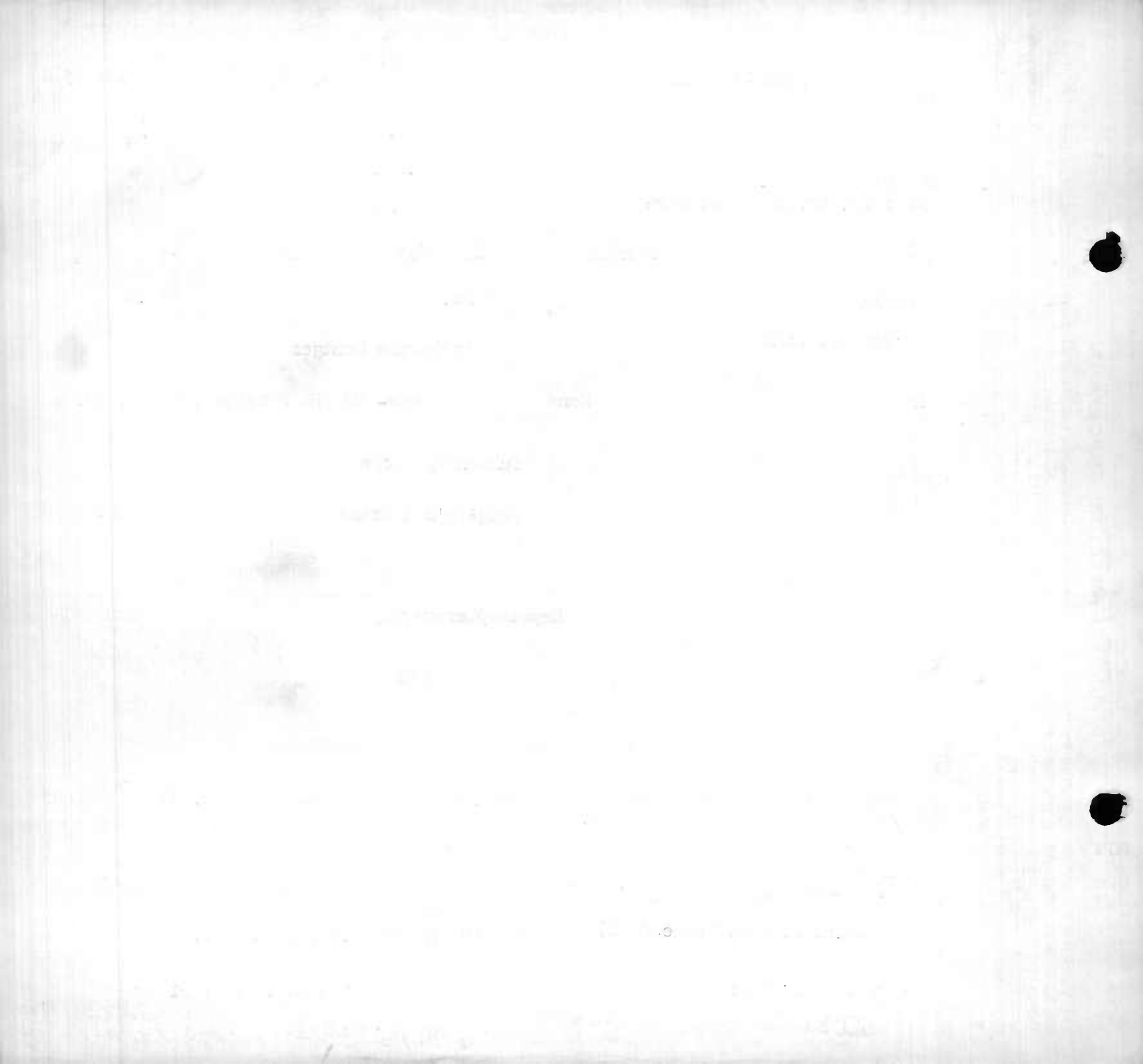
| | | | | | |
|--|--------------|--|------------------------------|---|--|
| BIRTH NO. 65 13192 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13192 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN E. CALAIN | | 2. DATE AND HOUR OF DEATH 12/23/65 1:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | 5. AGE (In years last birthday) | |
| FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS 601 N BROADWAY 21205 | | A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dandalk D. STREET ADDRESS (If rural, give location) 8155 KAVANAUGH ROAD | | 6. DATE OF BIRTH 12/24/65 7. AGE (In years last birthday) 3 days | |
| 5. SEX MALE | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 12/24/65 | 9. AGE (In years last birthday) 3 days | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JOHN M. CALAIN | | 14. MOTHER'S MAIDEN NAME Eliza Shaver | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Eliza Calain same address as above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cyantotic congestive heart failure | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 72 hours | |
| 19. DATE OF OPERATION 20 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 0 | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/22 3pm 1965 to 12/23 3am 1965, that (I) (we) last saw the deceased alive on 12/23 2am 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert S. Thompson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT S. THOMPSON | | 23D. ADDRESS 601 N BROADWAY 21205 | | 23E. FUNERAL DIRECTOR Wm. J. Tichenor & Sons | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 12/24/1965 | | 24C. NAME OF CEMETERY or CREMATORY Elkins, West Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert S. Thompson | | 25C. FUNERAL DIRECTOR Wm. J. Tichenor & Sons | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

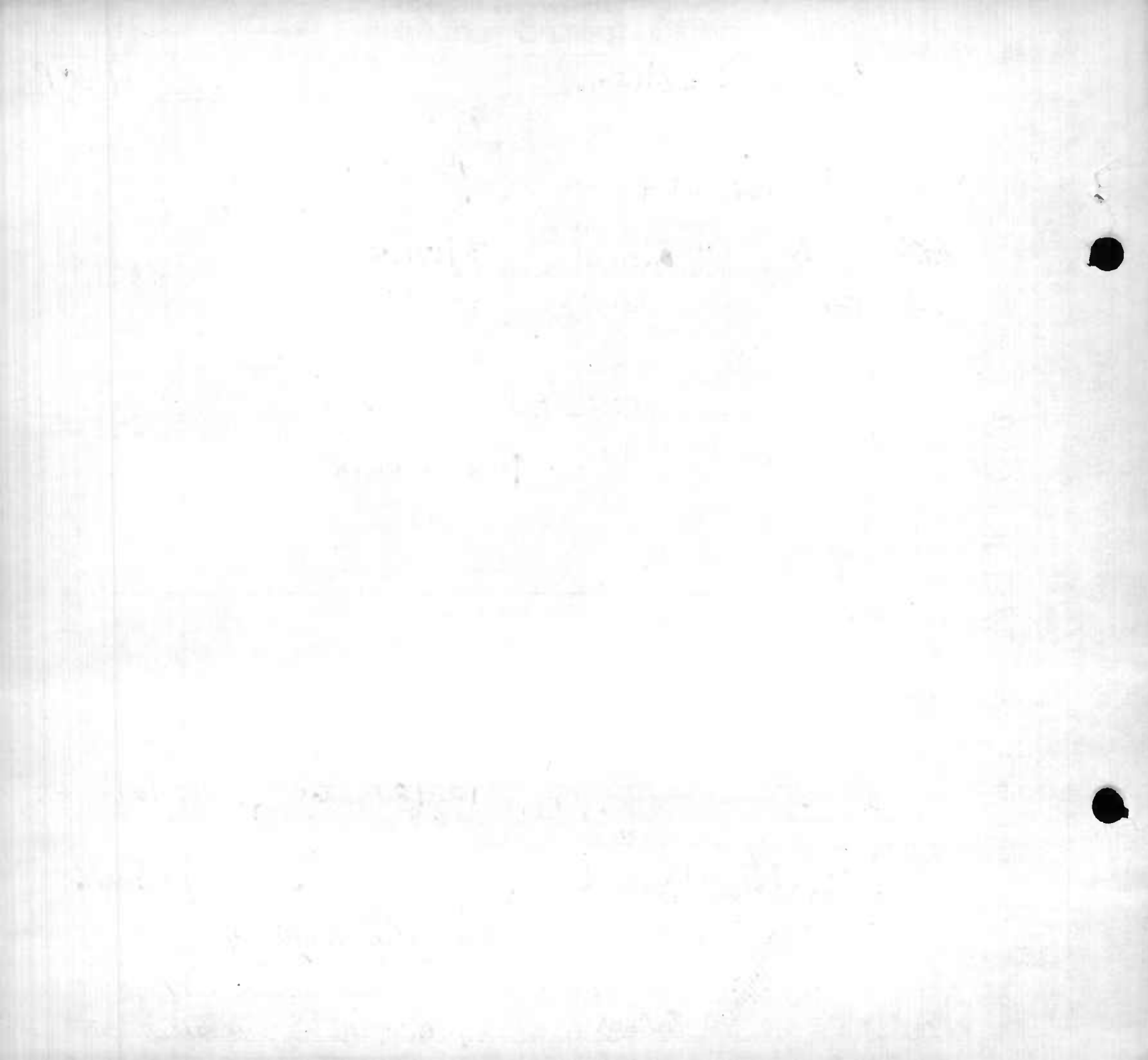
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|---|--|--|--|--|--|
| BIRTH NO. 65 13193 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13193 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | John Jay Lamm | | Dec. 23, 1965 12: 55 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | | Mo. V-22 | |
| 5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH 9. AGE (In years last birthday) | |
| M W Single | | | | 12/19/53 12 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | |
| Student | | | | Mo. | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | |
| Beasmore Lamm | | | | Catherine Mentges | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | |
| No | | | | None | |
| 17. INFORMANT | | | | ADDRESS | |
| Records- US PHS Hospital, Balto, Md. | | | | Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| 201X1 | | | | Pulmonary edema | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | |
| ANTECEDENT CAUSES | | | | Hodgkin's disease | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | |
| II | | | | Hepatosplenomegaly | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| <input type="checkbox"/> | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 28 19 65 to Dec. 23 19 65 , that (I) (we) last saw the deceased alive on Dec. 23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
|  | | | | 12/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Thomas J. Lau, Surgeon (R) | | | | US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Removal | | 12/23/1965 | | Sedalia, Missouri | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 27 1965 | | Robert E. Fisher | | Wm. J. Fisher & Sons | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|---------------------------------|----------------------------------|
| 65 13194 | | 65 13194 | | 65 13194 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Sandy Jackson | | 12/21/65 11:40 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. | | B. COUNTY 18-02 | |
| University | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Balto | |
| | | D. STREET ADDRESS (If rural, give location) | | 318 Schroeder St | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Male | N | Divorced | 3/17/100 | 65 | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Baker | | Bakery | Broadneck Va. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| West Jackson | | | Susan Harris | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS |
| No | | 212-09-6440 | Lillian Kane | | 1001 Edmondson Ave. |
| 18. 493X I | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) PNEUMONIA | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/21/1965 to 12/21/1965, that (I) (we) last saw the deceased alive on 12/21/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Jonathan Turk | | 12/22/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Jonathan Turk | | University Hospital | | | |
| 24A. BURIAL REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 12/27/65 | Artus Memorial | Artus Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 27 1965 | W. E. E. Jackson | William's Funeral Home | | 318 Schroeder St. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13195 | |
|--|-------------------------|---|--------------------------------------|---|---|
| BIRTH NO. 5-436 65 13195 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Slate, Laura</u> | | 2. DATE AND HOUR OF DEATH <u>12-22-65</u> <u>9:10 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>8-06</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1629 N. Wolfe Street 21213</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>5-20-1897</u> | 9. AGE (In years lost birthday) <u>68</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>S. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>Jim White</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Minnie</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>219-18-8850</u> | | 17. INFORMANT <u>RECORDS: BCH 4940 Eastern Avenue</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>5-81-01</u> | | CAUSE OF DEATH (A) <u>Hypertension, Shock</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Renal failure, GI bleeding</u> DUE TO | | <u>2 months</u> | |
| (C) <u>Cerebral - Esoph. Varices</u> | | | | <u>1 year</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21F. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>12-22-65 5PM</u> 19 <u>65</u> to <u>12-22 9¹⁰PM</u> 19 <u>65</u> , that (1) (we) last saw the deceased alive on <u>12-22- 9¹⁰PM</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Brian B. Bouton</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>11-22-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>BRIAN B. BOUTON</u> | | 23D. ADDRESS <u>BCH 4940 Eastern Avenue 21224</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12/27/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mount Calvary Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Arundel Co. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Reed H. F. F. F.</u> | | 25C. FUNERAL DIRECTOR <u>I. L. Brown & Son</u> | | | |
| ADDRESS <u>123 W. Montgomery St.</u> | | | | | |

Boat House City Harbor

13A

Boat House City Harbor
Boat House City Harbor
Boat House City Harbor

15-55-01 2000
15-55-01 2000
15-55-01 2000

Boat House City Harbor
Boat House City Harbor

428

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 3-65 13196 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13196 | |
|--|---------------------|---|--------------------------------------|---|-----------------------------|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>IRVING C. Taylor</u> | | | | 2. DATE AND HOUR OF DEATH <u>12-25-65</u> <u>8³⁵ AM</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>29-16-05</u> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 29</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>794 Linwood Street</u> | | | |
| 5. SEX <u>m</u> | 6. RACE <u>w</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>Nov. 7/02</u> | 9. AGE (In years last birthday) <u>63</u> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Bon Secours Hosp</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Chester Taylor</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY Acton</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Clara V. Taylor</u> <u>Wife</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Coronary thrombosis 5 days</u> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>A.S.C. W.D.</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/20/1965</u> to <u>12/25/1965</u> , that (I) (we) last saw the deceased alive on <u>12/25/1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Gholam Reza Pezeshkian</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/25/1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>GHOLAMREZA PEZESHKIAN</u> | | | | 23D. ADDRESS <u>BON SECOURS HOSPITAL</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/28/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Paradise</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto 7</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1965</u> | | 25B. NAME OF REGISTRAR <u>R. E. E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>W. J. L. 410/Edmondson</u> | | ADDRESS | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD A. SCHWARTZ

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1965 4:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

804 W. Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 19/34

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY

W S A

13. FATHER'S NAME

Samuel Schwartz

14. MOTHER'S MAIDEN NAME

Mildred

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

316-18-6535

17. INFORMANT

Elmer K. Schwartz

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Liver.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/22/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/24/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Natl. Bk.

23D. LOCATION

(City, town, or county)

(State)

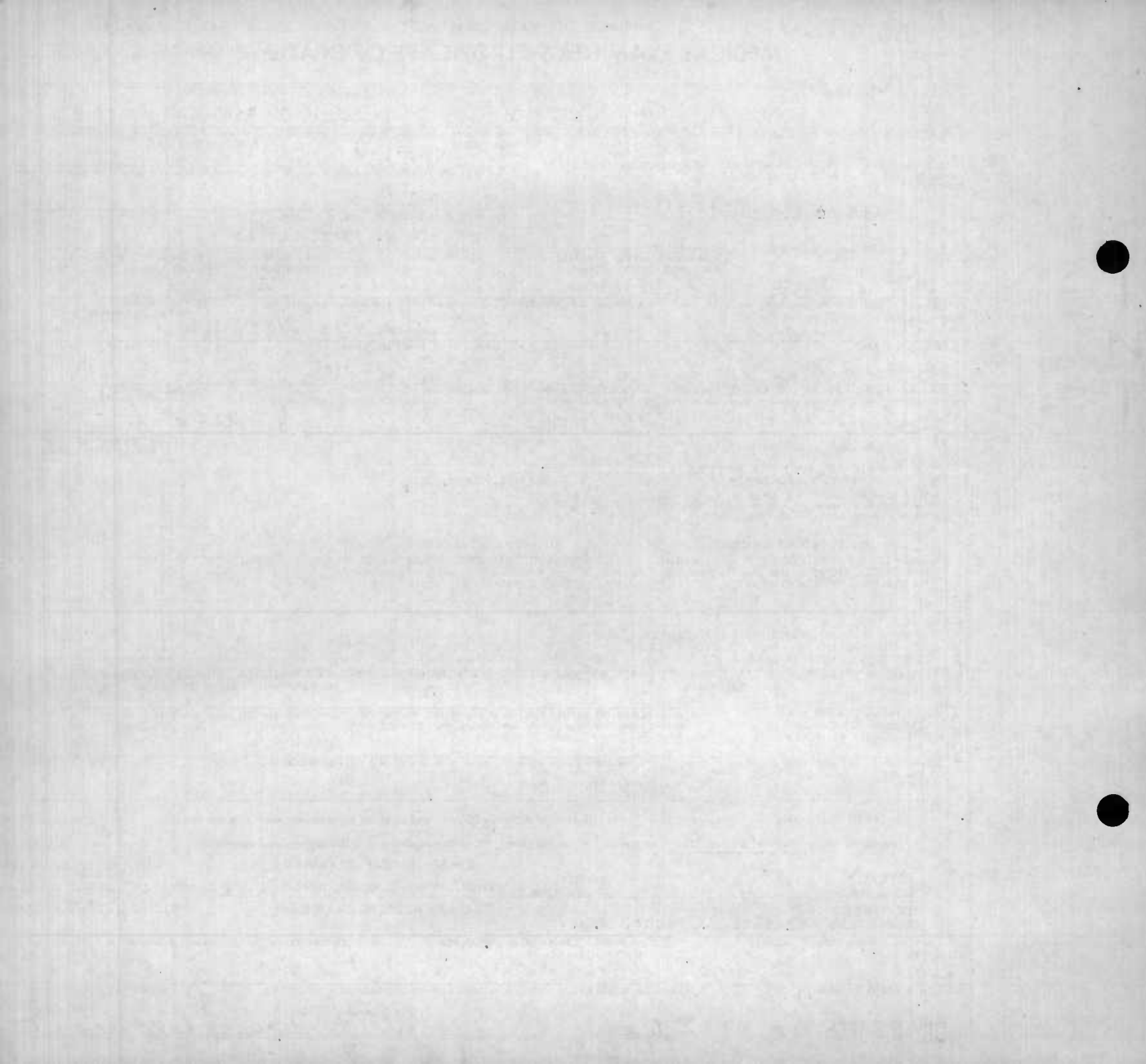
Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

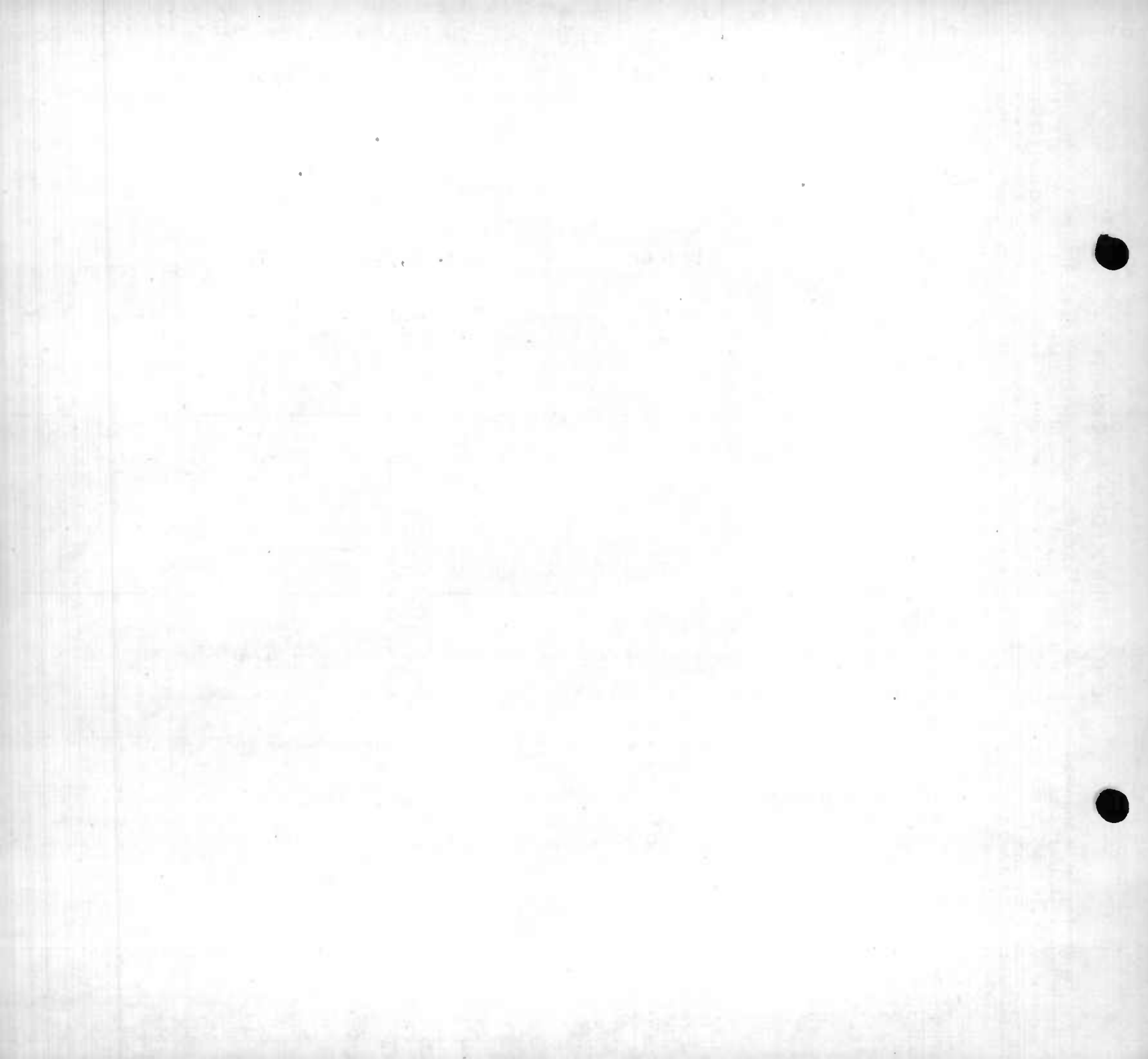
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------------------|--|---------------------------------------|--|--|
| BIRTH NO. <u>4 65 13198</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 13198</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Harold E. Walstow</u> | | 2. DATE AND HOUR OF DEATH <u>12/25/65</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>420 Random Rd.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>420 Random Rd</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widower</u> | B. DATE OF BIRTH <u>Nov. 5./93</u> | 9. AGE (In years lost birthday) <u>72</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u> | | 11. BIRTHPLACE (State or foreign country) <u>England</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>40 yrs U.S.A</u> | | 13. FATHER'S NAME <u>Late Edmund Walstow</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Arthur Hippo. 420 Random</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>162.1 I</u> <u>Bronchogenic Carcinoma</u> | | CAUSE OF DEATH (A) <u>Due To</u> (B) <u>Due To</u> (C) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>August 24 1965</u> to <u>December 25 1965</u> , that (I) (we) last saw the deceased alive on <u>December 16 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>M. W. Steinberg</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/27/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MORRIS W. STEINBERG</u> | | 23D. ADDRESS <u>3913 HOLLINS FERRY Rd, LANDSOWNE 27 Md.</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12/28/65</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Garden of Eternity Balto. Md</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Dec 28, 1965</u> | | 25C. FUNERAL DIRECTOR <u>W. H. F. N. 4106</u> | |
| | | | | ADDRESS <u>Edmondson</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|--|--|--|
| 65 13199 BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) DAVID L. MILLER | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13199 2. DATE AND HOUR OF DEATH 12-17-65 9:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY TAMAQUA C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-35 D. STREET ADDRESS (If rural, give location) 229 W. BROAD STREET | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 6/7/07 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Publisher | | 10B. KIND OF BUSINESS OR INDUSTRY Dunford, Pa | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wm. F. Miller | | | 14. MOTHER'S MAIDEN NAME Esthina | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? | | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT Hosp. Records Helen Miller |
| 18. 705.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ? | | | CAUSE OF DEATH (A) GI PERFORATION DUE TO (B) CHRONIC OBSTRUCTIVE AIRWAY DZ DUE TO (C) LUPUS ERYTHEMATOSIS | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 1 19 65 to Dec 17 19 65 , that (I) (we) last saw the deceased alive on Dec 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert S. Stone M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 10:10 PM | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT T. STONE M.D. | | | | 23D. ADDRESS 4202 GREENWAY, 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 12/18/65 | | 24C. NAME OF CEMETERY or CREMATORY Tamaqua, Pa. | |
| 24D. LOCATION (City, town, or county) (State) Tamaqua, Pa. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | |
| 25B. NAME OF REGISTRAR W. J. Edmondson | | 25C. FUNERAL DIRECTOR W. J. Edmondson | | | |

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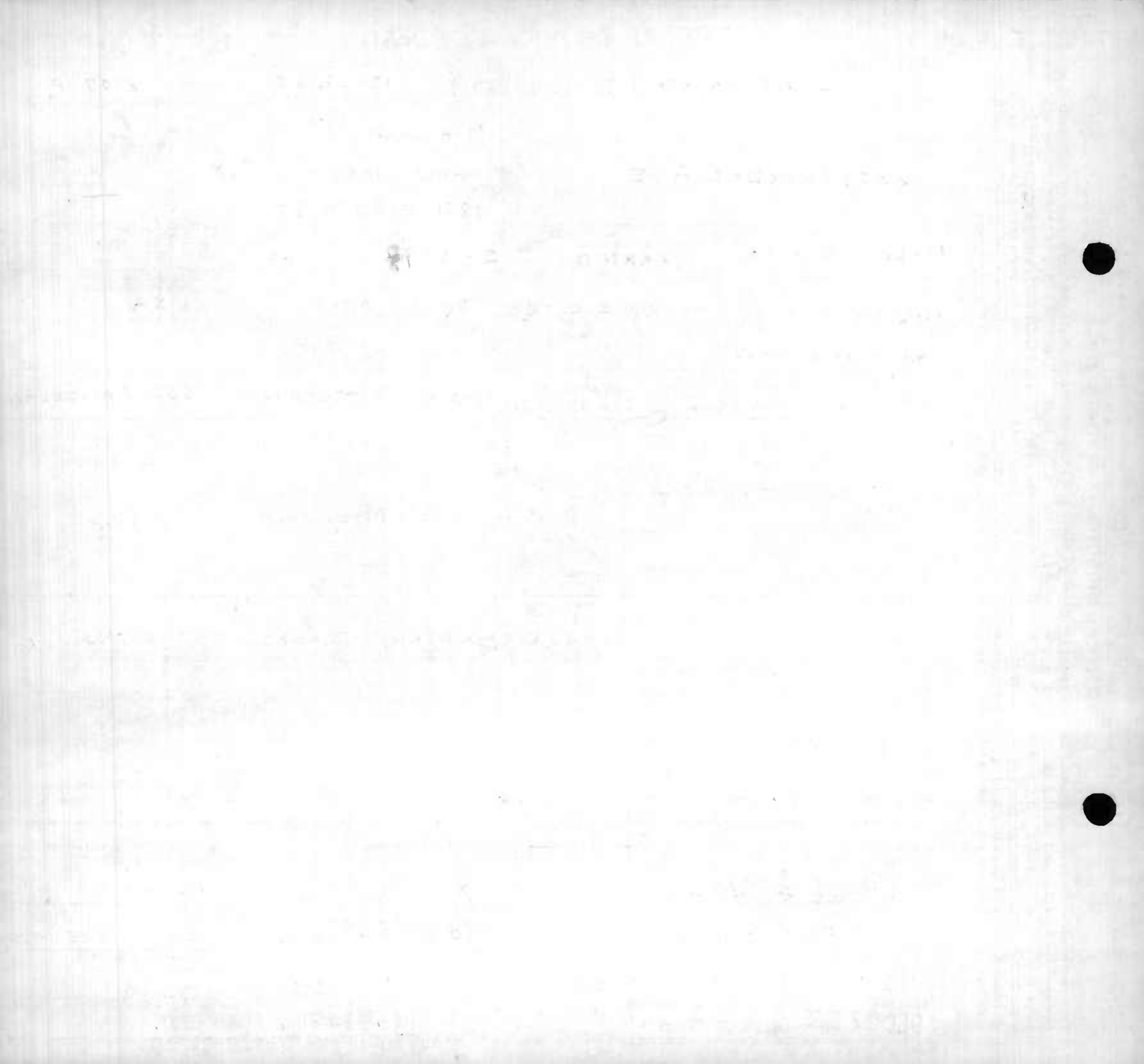
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13200 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13200 | |
|---|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | LOUIS LAIRD (LOUIS LAIRD) | | 12.22.65 6:07 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 6609 FAIRDEL AVE | | | | MARYLAND | | 7-06 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALTIMORE - 21218 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 1831 E. 30TH ST | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| MALE | | WHITE | | MARRIED | | 2-3-97 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| MILLWRIGHT | | WESTERN ELECTRIC | | ORIOLE, MD | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JOHN W. LAIRD | | | | NELLIE PARKS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES WORLD WAR I | | | | 216.03.5651 | | MRS WM. RITTERPUSCH 6609 FAIRDEL AV. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | 4 HRS | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | 2 YRS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CORONARY ARTERY DISEASE | | 5 YRS | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| O | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 10.18.1959 to 12.22.1965, that (I) (we) last saw the deceased alive on 12.19.1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Paul G. Herold | | | | | | 12.23.65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| PAUL G. HEROLD | | | | 10 W. MADISON ST, BALTIMORE MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/24/65 | | Parkwood | | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 27 1965 | | Paul G. Herold | | HENRY SANDER & SONS INC. | | BALTIMORE MARYLAND 21213 | |



BIRTH NO. 65 13201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13201

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ADDIE WORTHEN 2. DATE AND HOUR PRONOUNCED DEAD 12/24/65 6:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX female 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH March 3, 1903 9. AGE (In years last birthday) 62 If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Downs 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Charles Worthen 1332 W. Lafayette Ave. ADDRESS

18. 353.21 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Status epilepticus DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 12/24/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 12/28/65 23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem. 23D. LOCATION (City, town, or county) (State) Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS

March 3, 1903
Baltimore, Md.

My dear Mr. [illegible]

Many thanks

Yours very truly

1/24/02
Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---|--|--|---|------------------------------|
| 65 13202 | | CERTIFICATE OF DEATH | | 65 13202 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | HARRIS, SARAH | | DEC 24, 1965 11:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| UNIVERSITY HOSPITAL | | MARYLAND | | BALTIMORE | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) | | 617 GLENDEN STREET 21216 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| F | NEGRO | MARRIED | 3-7-28 | 37 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 17. INFORMANT | |
| JOHN ELOPE | | LOU ? | | PATIENT | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | ADDRESS | |
| No | | 320-24-6332 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) NEUROFIBROMATOSIS | | 35 yr. | |
| ANTECEDENT CAUSES | | (B) SARCOMATOUS DEGENERATION | | 2 yr. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) OF LEFT APICAL LUNG NEUROFIBROMA | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | NONE | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| AUG 1965 | Remove LEFT APICAL TUMOR | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| NO | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 4, 1965 to Dec 24, 1965, that (I) (we) last saw the deceased alive on Dec 24, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Charles S. Harrison | | | | Dec. 24, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 12/29/65 | Bethg. Natl. Cem. | Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 27 1965 | Robert E. Taylor | George A. Kline | | 1348 N. Calhoun St | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM WILEY

2. DATE AND HOUR PRONOUNCED DEAD

25 December 1965 11:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2968 Cherryland Rd.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 15, 1939

9. AGE (In years
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Wiley

14. MOTHER'S MAIDEN NAME

Calvert Wabers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Annie Wiley 405 Mt Holly St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of chest

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

house

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

339 Scott St.

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12/25/65 10:50 p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/26/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/30/65

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

(State)

Arbutus, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 27 1965 P.O. 18 J. B. M. H.

George A. Kila 1348 N. Calhoun St

WALTER H. HARRIS

March 12, 1930

Sampled

Calvert Wagers

John Wiley

Amie Wiley 202 W. 10th St.

no

Amie Wiley 202 W. 10th St. Amie Wiley 202 W. 10th St.

1

65 13204

BIRTH NO. 65 13204

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13204

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ETHEL TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD 12/23/65 7:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-04

D. STREET ADDRESS (If rural, give location) 1809 Clifton Ave.

5. SEX female

6. RACE colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed

8. DATE OF BIRTH July 6, 1908

9. AGE (In years last birthday) 57

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME XXXX Charles Butler

14. MOTHER'S MAIDEN NAME Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Nellie Johnson 1036 Edmondson Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz, M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 12/24/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 12/28/65

23C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem.

23D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT. DEC 27 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

24D. ADDRESS

WALFLEX FORTGE

THE GARDEN BUDGET

WILSON

July 1, 1900

Belmont, N.Y.

Elizabeth

Belmont Johnson 1030 Belmont Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|-----------------------------|--|--|
| BIRTH NO. 65 13205 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13205 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Alfred George Jaschik | | 2. DATE AND HOUR OF DEATH 12/22/65 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) S B G H | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 25-84 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 3813 S. Hanover St. | | | |
| 5. SEX m | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6/28/88 | 9. AGE (In years last birthday) 77 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Cloth. Cutter | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME Unk | | 14. MOTHER'S MAIDEN NAME Unk | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO CEREBRO-VASCULAR ACCIDENT (B) DUE TO ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 Hour 7-8 YEARS | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 1962 to DECEMBER 1965, that (I) (was) last saw the deceased alive on DECEMBER 15 1965 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | |
| 22A. SIGNATURE M. L. De Vincentis | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 22B. DATE SIGNED 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) M. L. DE VINCENTIS | | 23D. ADDRESS 1202 ST. PAUL STREET | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/24/65 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR McCully Funeral Hm. 237 Patapsco Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|------------------------|--|---|--|------------------------------|
| 65 13206 | | 65 13206 | | 65 13206 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| James R Thompson | | 12-22-65 16:22 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| South Baltimore General Hosp. | | Maryland 2504 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore #21225 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3601st Victor St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| M. | White | Married | 2-15-15 | 50 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Foreman | | Daw & Son Co | | VA. Va. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Ernest Thompson | | Fannie Edwards | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | Family Home | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | Primary Leptoma (Chin) | | Approx. 4 mos. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | Liver cirrhosis (alcoholic), generalized | | | |
| II | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | Liver biopsy | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/5/65 to Dec. 22 1965, that (I) (we) lost saw the deceased alive on Dec. 21 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Romulo V. Goco | | | | 12/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| ROMULO V. GOCO, M.D. | | 707 E. Fort Ave. #30. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 12-27-65 | Green Haven Cem | Ellen Burrend | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 27 1965 | John F. G. G. G. | McGilly 237 Patapascue | | John | |

CERTIFICATE OF DEATH

Registered No. 65 13207

BIRTH NO. 65 13207

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

(Fred Haines) FREDERICK F. HAINES

2. DATE AND HOUR OF DEATH

12-20-1965

10:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location) 109 N. CAREY STREET

1425 West Fayette Street 21223

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

May 3, 1887

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Labor

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL
SECURITY NO.

212-12-1354

17. INFORMANT

MRS. GERTRUDE H. STAMM, 4833 WILLISTON
Records: BCH-4940 Eastern Avenue 21224 ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 20 1965 to Dec 20 1965,
that (I) (we) last saw the deceased alive on Dec 20 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Patrick Caulfield

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-20-65

23C. PHYSICIAN'S
NAME (Type)

J. Patrick Caulfield

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore,
BCH. Maryland24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/24/65

24C. NAME of CEMETERY or CREMATORY

New Cathedral

24D. LOCATION

(City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 27 1965

25B. NAME OF REGISTRAR

Robert E. Hubbard

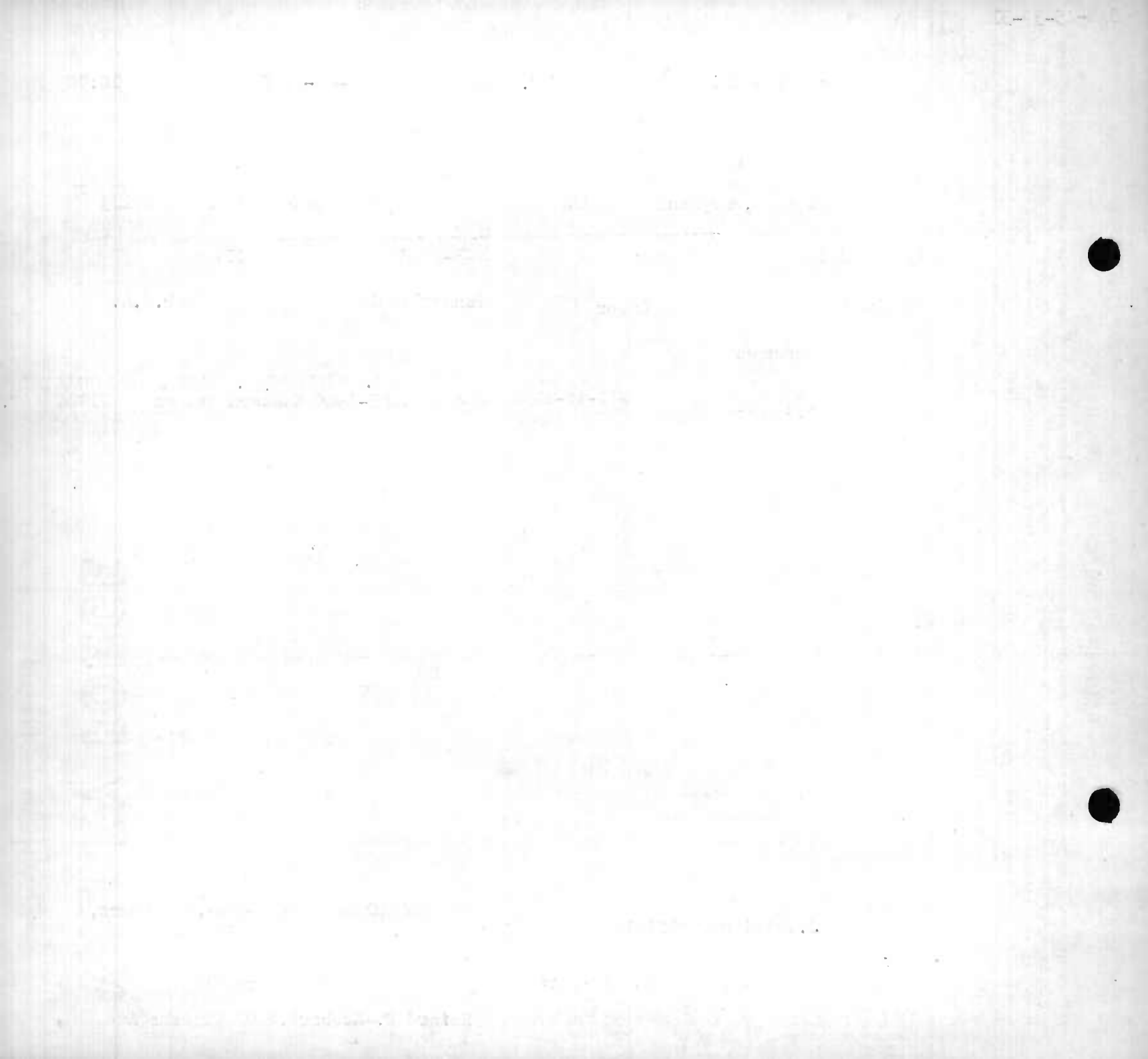
25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|---|---|---|
| BIRTH NO. 65 13208 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13208 | |
| 1. NAME OF DECEASED (Type or Print) STRAW, RALSTON M. | | | 2. DATE AND HOUR OF DEATH 12-21-65 2:05A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 27 D. STREET ADDRESS (If rural, give location) 2738 DAISY AVENUE | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2-23-85 | 9. AGE (In years lost birthday) 80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER | | 10B. KIND OF BUSINESS OR INDUSTRY RAILROAD | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME WILSON STRAW | | | 14. MOTHER'S MAIDEN NAME EMMA NIEWIG | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 705-05-3687 | | 17. INFORMANT Ethel T. Straw, 2738 Daisy Avenue ST. AGNES RECORDS -CATON & WILKENS AVE | |
| 18. 50201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) Rupture of Emphysema bleb DUE TO (B) Cor pulmonale - Chronic DUE TO (C) Bronchitis - Emphysema with a big bleb - Coagulative fracture INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 11 19 65 to DECEMBER 21 19 65 , that (I) (we) last saw the deceased alive on DECEMBER 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cemil Gobal | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) CEMIL GOBAL | | | | 23D. ADDRESS ST. AGNES HOSPITAL -CATON & WILKENS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/23/65 | | 24C. NAME OF CEMETERY or CREMATORY MOUNTAIN VIEW CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) UNION BRIDGE, MARYLAND (CARROLL CO) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | BIRTH NO. 65 13209 | | CERTIFICATE OF DEATH | | Registered No. 65 13209 | |
|---|-------------------------|---|--|--|--|---|-----------------------|-------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) MAGDALEN NMN LOCHNER | | 2. DATE AND HOUR OF DEATH DEC. 24, 1965 12:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 6-02 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 412 N. KENWOOD AVE. | | | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH FEB. 27, 1876 | 9. AGE (In years lost birthday) 89 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME JAMES BADINGER | | | | 14. MOTHER'S MAIDEN NAME Teresa Hurgal THERESA HERGEL | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. UNK. | | 17. INFORMANT MISS VICTORIA LOCHNER | | ADDRESS dght SAME | | | |
| 18. 4-22-71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL VASCULAR ACCIDENT (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 20 days | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) ARTERIOSCLEROTIC CARDIOVASCULAR Ds. DUE TO | | 40 years | | | |
| (C) _____ | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that the (this hospital) attended the deceased from DEC. 5 19 65 to DEC. 24 19 65 , that we (we) last saw the deceased alive on DEC. 24 19 65 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE L. Evan Custer | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED DEC. 24, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) L. EVAN CUSTER | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Galt | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | ADDRESS 13381 Brehms Lane | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|------------------|--|---------------------------------|
| BIRTH NO. R-16065 13210 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13210 | |
| M.E. CASE NO. | | GIL | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Ellis Rivera | | 12-23-1965 3.45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | Maryland | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | 408 North Haven Street | | 21224 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Male | White | Married | 8-24-1899 | 66 | 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Hog Dresser | | Esskey Meat Packers | | Spain | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Unknown | | Unknown | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| yes WWII | | 213-01-4868 | | Rose Rivera, Above, wife. | |
| | | | | ADDRESS | |
| | | | | Records: BCH-4940 Eastern Avenue 21224 | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) DUE TO | | 1 hr. | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | 1 wh. | |
| ANTECEDENT CAUSES | | (C) DUE TO | | 20 yrs | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | LLC of lung collapse. | | 2 wh. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | NO | | 20A. AUTOPSY (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| I (Month) I (Day) (Year) I (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 12/23 1965 | | to 12/23 1965 | |
| that (I) (we) last saw the deceased alive on | | 12/23 1965 | | and that in (my) (our) opinion death occurred on the date | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| G. Gey | | 12-23-1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| G. Gey | | 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/27/65 | | Baltimore National Cemetery | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 27 1965 | | R. E. J. J. J. | | Schimunek Funeral Home, Inc. | |
| | | | | 3331 Brehms Lane #13 | |

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my-My, my, my

OM

no. 10/11/11

10/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|----------------------------------|--|-------------------------|--|
| BIRTH NO. 65 13211 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13211 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) IRENE L. HULSE | | |
| 2. DATE AND HOUR OF DEATH Dec 25, 1965 10:15 A.M. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-06 | | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| 6. STREET ADDRESS (If rural, give location) 6263 BIRCHWOOD AVE | | | 7. MARITAL STATUS (Specify) MARRIED | | |
| 8. DATE OF BIRTH 3/3/18 | | | 9. AGE (In years last birthday) 47 | | |
| 10. SEX FEMALE | | | 11. RACE WHITE | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Fredrick Kircher | | |
| 14. MOTHER'S MAIDEN NAME CAROLINE WETZEL | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS UNEPICAL RECORD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X I | | | CAUSE OF DEATH (A) Pulmonary Infarction (B) Pulmonary Embolus (C) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (d) Diabetes mellitus | | |
| 19. DATE OF OPERATION 12-17-65 | | | 20. AUTOPSY? (Yes or No) YES | | |
| 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 23. PHYSICIAN'S NAME (Type) FLORENCE de la MERCE | | | 24. NAME OF CEMETERY OR CREMATORY CHURCH HOME HOSPITAL | | |
| 25. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | | 26. FUNERAL DIRECTOR ADDRESS 5305 Harbor | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 13212 | |
|--|--|---------|--|--|--|------------------------------------|--|--|--|---|--|
| 65 13212 | | | | | | | | | | BIRTH NO. | |
| M.E. CASE NO. | | | | | | | | | | 1. NAME OF DECEASED | |
| | | | | | | | | | | (Type or Print) | |
| KING, MURRELL E. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | |
| | | | | | | | | | | 12/25/65 11:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | | | | | A. STATE B. COUNTY | |
| U.S.P.H.S. HOSPITAL | | | | | | | | | | PENNSYLVANIA | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | | | | | | | PITTSBURGH | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | | | | | | | 616 SHORE AVE | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| MALE | | WHITE | | MARRIED | | 9/8/06 | | 39 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| STRIKER - ENGINEER | | | | AMERICAN SEAMAN | | | | KENTUCKY | | USA | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| MARK KING | | | | | | MINNIE BLOODSWORTH | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| UNKNOWN | | | | | | 406 079281 | | RECORDS - USPHS HOSP., BALTO, MD, | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | CAUSE OF DEATH | |
| | | | | | | | | | | (A) MALIGNANT BRAIN TUMOR | |
| | | | | | | | | | | DUE TO | |
| | | | | | | | | | | (B) DUE TO | |
| | | | | | | | | | | (C) DUE TO | |
| 19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | 87 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 11/23/65 | | | | BRAIN TUMOR | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| NO | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 20 1965 to Dec. 25 1965, that (I) (we) last saw the deceased alive on Dec. 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | 23B. DATE SIGNED | | | |
| Rex M. Crago MD | | | | | | | | 12/25/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS | | | |
| REX M. CRAGO, SURG. (R) | | | | | | | | USPHS HOSPITAL, BALTO, MD, | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | | | 12/29/65 | | Uniondale Cemetery | | | | Pittsburgh, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| DEC 27 1965 | | | | Rex M. Crago, M.D. | | | | Rex Funeral Home 5303 Harford Rd | | | |

1. The first part of the report is devoted to a general description of the project and its objectives.

2. The second part of the report describes the methodology used in the study.

3. The third part of the report presents the results of the study.

4. The fourth part of the report discusses the conclusions of the study.

5. The fifth part of the report contains the references.

6. The sixth part of the report contains the appendix.

7. The seventh part of the report contains the summary.

8. The eighth part of the report contains the acknowledgments.

9. The ninth part of the report contains the conclusion.

10. The tenth part of the report contains the final remarks.

11. The eleventh part of the report contains the list of figures.

12. The twelfth part of the report contains the list of tables.

13. The thirteenth part of the report contains the list of abbreviations.

14. The fourteenth part of the report contains the list of symbols.

15. The fifteenth part of the report contains the list of equations.

16. The sixteenth part of the report contains the list of formulas.

17. The seventeenth part of the report contains the list of diagrams.

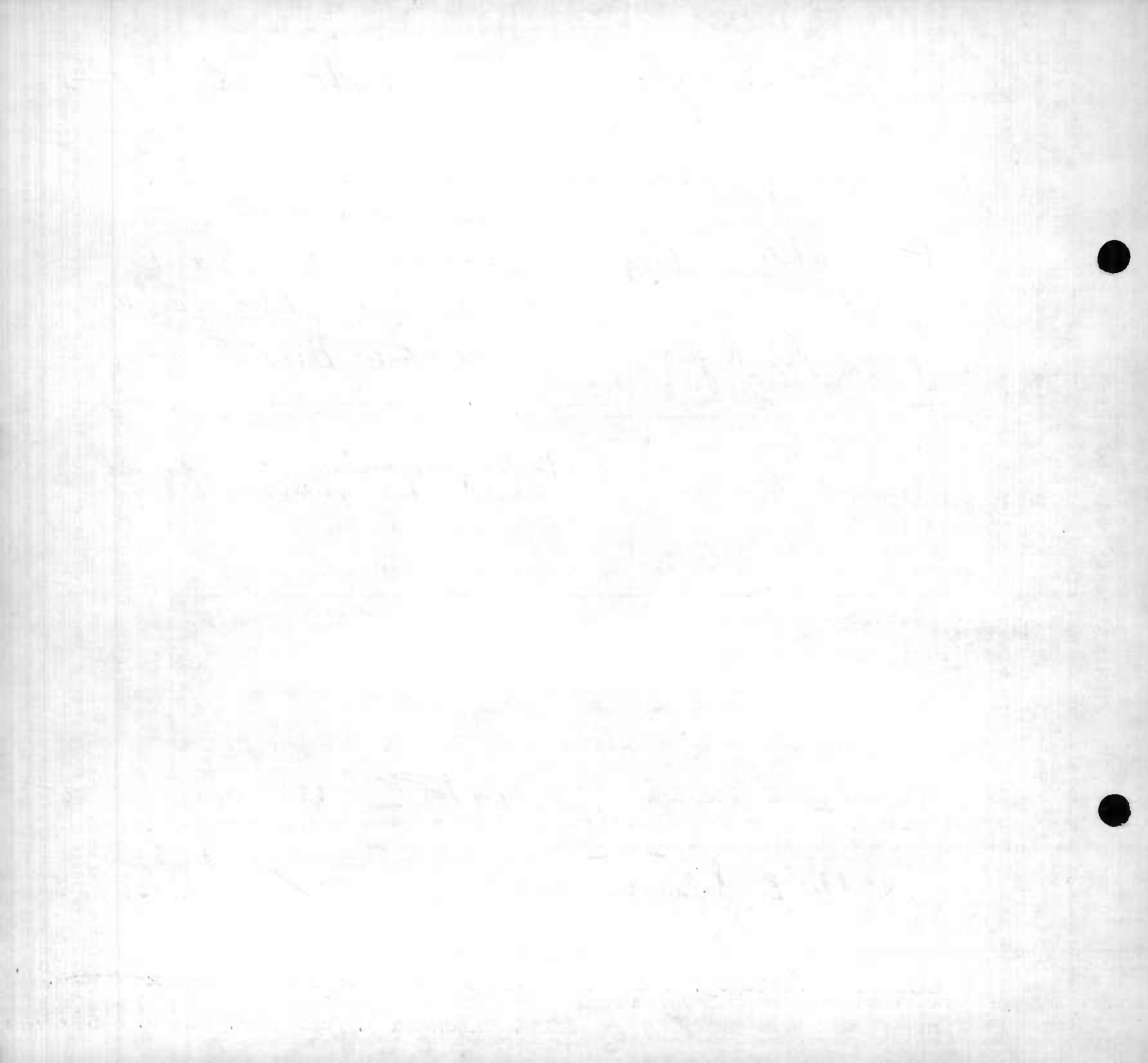
18. The eighteenth part of the report contains the list of graphs.

19. The nineteenth part of the report contains the list of charts.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

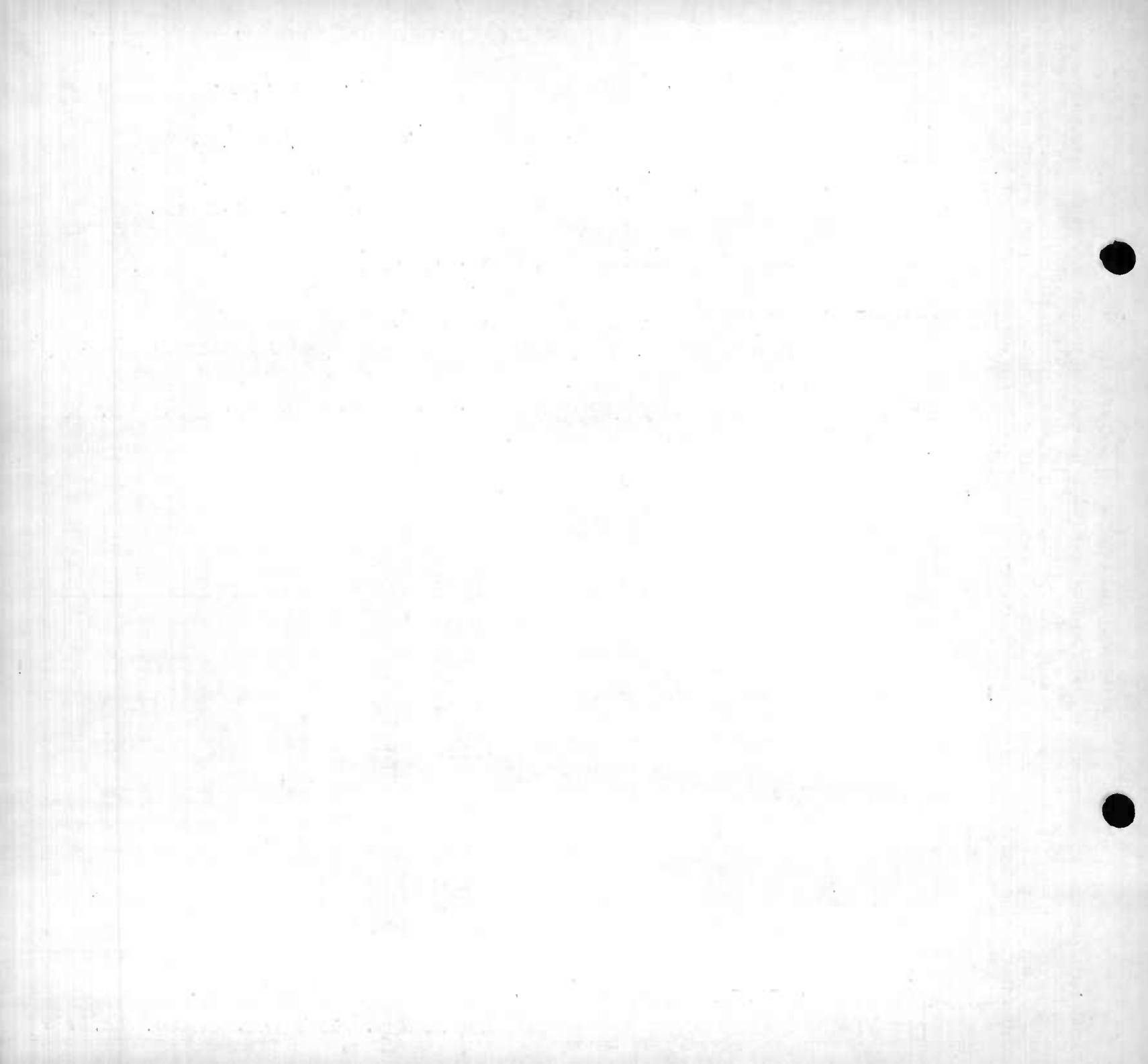
| | | | | | | | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. 65-16846 | | 65 13213 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13213 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Jennie Di Angelo</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>12/25/65 7:25 AM</i> | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | | 5. SEX <i>F</i> 6. RACE <i>white</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | 8. DATE OF BIRTH <i>6/24/65</i> 9. AGE (In years last birthday) <i>6</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>6208 Alta Ave.</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland, U.S.A.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>James Di Angelo</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Christine Mondet</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT ADDRESS <i>Mr. James Di Angelo (Same)</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Marked dehydration & acute renal failure</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>43 hrs. approx.</i> | | | |
| 19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/24/65</i> to <i>12/25/65</i> that (I) (we) last saw the deceased alive on <i>12/25/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <i>Isabella B. Salas</i> | | 23B. DATE SIGNED <i>12/25/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/28/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>D. E. J. ...</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i> | | 25D. ADDRESS <i>Balto. Md. 21214</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13214 | |
|--|------------------------------|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 13214</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>Charles W. Schotta</i></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <i>Dec. 25, 1965</i> <i>10:24</i> M.</p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2816 Inglewood Ave.</i></p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>Md.</i> B. COUNTY <i>27-07</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>2816 Inglewood Ave.</i></p> | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | B. DATE OF BIRTH <i>Aug. 17, 1907</i> | 9. AGE (In years last birthday) <i>58</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired- Maintenance</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>William Schotta</i> | | | 14. MOTHER'S MAIDEN NAME <i>Minnie Schlichthorn</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>705079274</i> | 17. INFORMANT <i>Mrs. Alma Schotta</i> | | ADDRESS <i>(Same)</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Acute Coronary Thrombosis</i> DUE TO <i>ASCVD</i> (B) _____ DUE TO _____ (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>Several hours</i> <i>5 years</i> |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <i>Feb 19 60</i> to <i>Dec 25 19 65</i>, that (I) (we) last saw the deceased alive on <i>Dec 18 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.</p> | | | | | |
| 23A. SIGNATURE <i>Geo H. Beck</i> M.D. | | | | 23B. DATE SIGNED <i>12/27/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>GEORGE H. BECK MD</i> | | 23D. ADDRESS <i>6012 Harford Road Balto, Maryland</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | 24B. DATE <i>12-29-65</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Schott</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|------------------------------------|--|--|
| BIRTH NO. 65 13215 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13215 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| George J. Herbert, Jr. | | Dec. 25, 1965. | | 11:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. | | | |
| 1204 E. 36th. Street | | B. COUNTY 9-03 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1204 E. 36th Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 27, 1901 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optician | | 10B. KIND OF BUSINESS OR INDUSTRY Self-Employed | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME George Herbert Sr. | | 14. MOTHER'S MAIDEN NAME Anna Streb | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 216326566 | | 17. INFORMANT Mrs. Helen M. Herbert | |
| | | | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Myocardial Infarction (B) Atherosclerotic Coronary Artery (C) | | INTERVAL BETWEEN ONSET AND DEATH acute 10 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19 65 to Dec 25 19 65, that (I) (we) last saw the deceased alive on Dec 23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles E. Carr | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED/ 12/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) Charles E. Carr | | 23D. ADDRESS M.D. 3900 N. Charles St. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12-29-65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR R. E. J. J. J. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214 | |

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|---------------------------------|---|--|--|--|--|---|
| BIRTH NO. 65 13216 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 13216 | |
| 1. NAME OF DECEASED (Type or Print) Thompson, William H. Sr | | | | | 2. DATE AND HOUR OF DEATH DECEMBER 26, 1965 12:15 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore, Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural give location) 428 S. PULROW ST | | | | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 5/23/03 | 9. AGE (In years last birthday) 62 | (If Under 1 Yr. Months Days) | | (If Under 24 Hrs. Hours Min.) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY TRANSIT CO | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Oliver Glenn Thompson | | | | | 14. MOTHER'S MAIDEN NAME ELLA | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Sharon Thompson | | ADDRESS 428 S. PULROW ST. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A. S. H. D. Pneumonia | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive Heart failure | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 64 to Dec 26 19 65, that (I) (we) last saw the deceased alive on Dec 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Antonio M. Estrada M.D. | | | | | 23B. DATE SIGNED 12-26-65 | | | 23C. PHYSICIAN'S NAME (Type) Antonio M. Estrada | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 12-29-65 | | 24C. NAME OF CEMETERY or CREMATORY London Park | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR George L. Schuch | | ADDRESS 2101 Fredrick Ave | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13217 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13217 | |
|--|-----------------------|--|--------------------------------------|---|----------------------------|--|-----------------------------|
| CERTIFICATE OF DEATH | | | | Registered No. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Bertha Adams</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/22/65 10³⁵ A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>MD.</i> | | B. COUNTY <i>15-13</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>2503 Park Hg. Ter.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>N N</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>4/19/1890</i> | 9. AGE (In years last birthday) <i>74</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i> | | 11. BIRTHPLACE (State or foreign country) <i>U.S.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Joe Anderson</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Smith</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>212-32-1443</i> | | 17. INFORMANT <i>Elizabeth Jones</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>720.141.260X</i> | | CAUSE OF DEATH (A) DUE TO <i>Acute Myocardial Infarction</i> <i>ASCVD.</i> | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | | | |
| (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes, Bronchopneumonia</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/22/65</i> to <i>12/22/65</i> , that (I) (we) last saw the deceased alive on <i>12/22/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>M. Savants</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/24/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS <i>Sinai Hosp</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/27/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Arbutusman R.K.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. J. ...</i> | | 25C. FUNERAL DIRECTOR <i>W. J. ...</i> | | ADDRESS <i>1701 M. E. ...</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13218 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13218 | |
|--|-------------------------|--|--|---|--|---|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) DAVID McMILLAN | | | | 2. DATE AND HOUR OF DEATH DEC 22, 1965 6:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1806 McCulloch St | | | | A. STATE Maryland B. COUNTY 14-83 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1806 McCulloch St | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Oct 1, 1880 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME George McMillan | | | | 14. MOTHER'S MAIDEN NAME Catherine | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Willie Sullivan - 1806 McCulloch St | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Coronary Thrombosis DUE TO (B) Generalized Senile DUE TO (C) Cerebral Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 20 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 22, 1965 to Dec 22, 1965 , that (I) (we) last saw the deceased alive on Dec 22, 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Geo H. Pendleton | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) Geo H. Pendleton | | | | 23D. ADDRESS 1723 Daniel Hill Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/65 | | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Edw E. Sullivan | | 25C. FUNERAL DIRECTOR Earl Gilmore - 1827 W. North Ave | | ADDRESS | |

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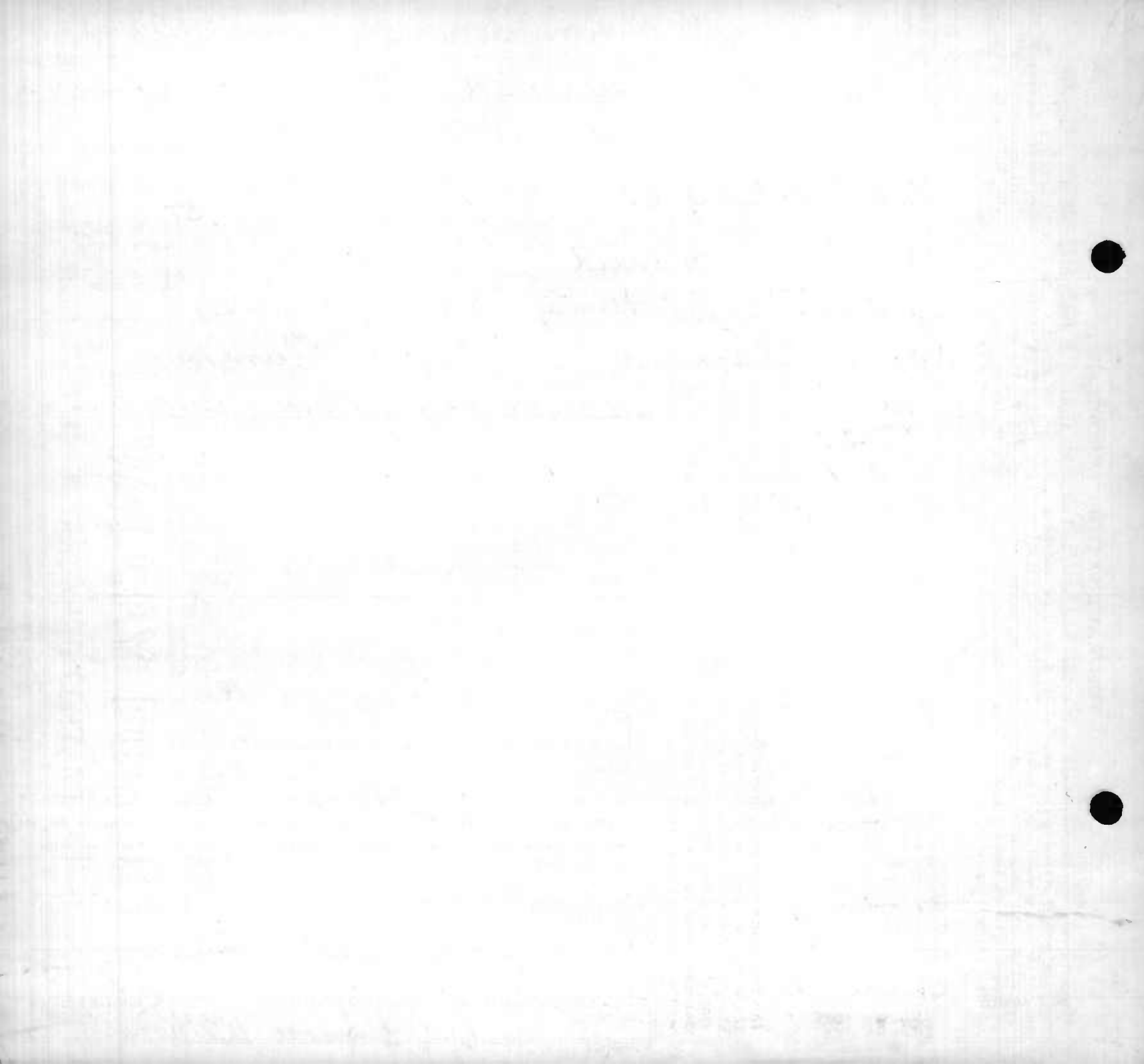
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Geo. H. P. H. P. H. P.
The Winton

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

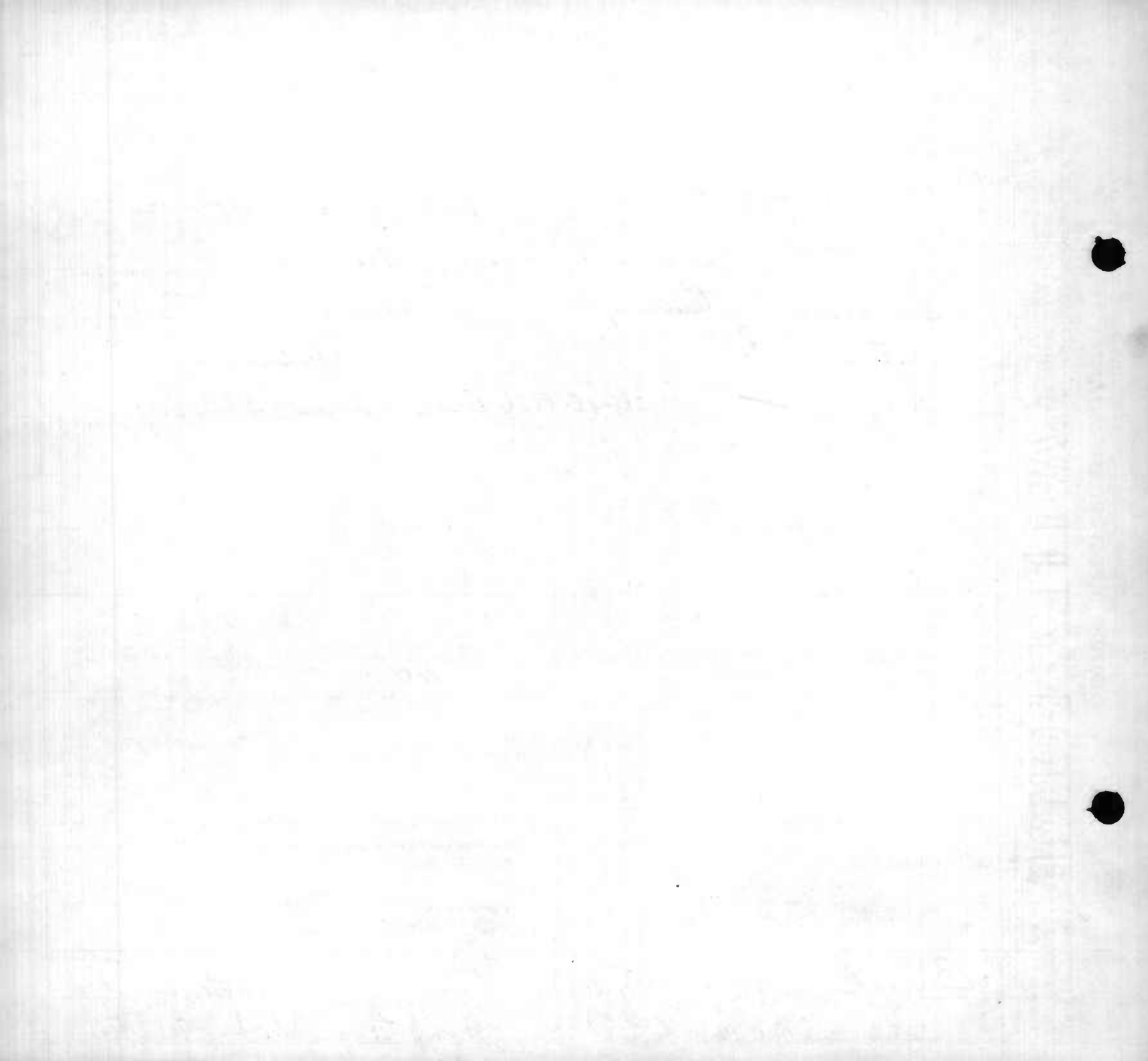
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|--|--|--|--|--|--|
| BIRTH NO. 65 13219 | | | | | Registered No. 65 13219 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) THOMAS W. PLUMMER | | | | | 2. DATE AND HOUR OF DEATH DEC. 22, 1965 12:50 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2915 Prechury St | | | | | A. STATE Maryland B. COUNTY 15-06 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 2915 Prechury St. | | | | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH July 31, 1885 | 9. AGE (In years, last birthday) 80 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker | | | 10B. KIND OF BUSINESS OR INDUSTRY Gov. Family | | 11. BIRTHPLACE (State or foreign country) Balto. Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Robert Plummer | | | | | 14. MOTHER'S MAIDEN NAME Rachel Plummer | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 215-32-1350 | | 17. INFORMANT Joseph Plummer | | | ADDRESS 2915 Prechury St | |
| 18. 44.3X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease | | | | | CAUSE OF DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 21, 1964 to December 22, 1965 , that (I) (we) lost saw the deceased alive on December 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Thomas J. Woodbridge Jr. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 12-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) Thomas J. Woodbridge Jr. | | | | | 23D. ADDRESS 703 W. Lafayette Ave. | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/65 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem Pk. | | | 24D. LOCATION (City, town, or county) (State) Arbutus Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | 25B. NAME OF REGISTRAR Robert E. Jackson | | | 25C. FUNERAL DIRECTOR Earl Edmore | | | |
| ADDRESS -1827 W. North Ave | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

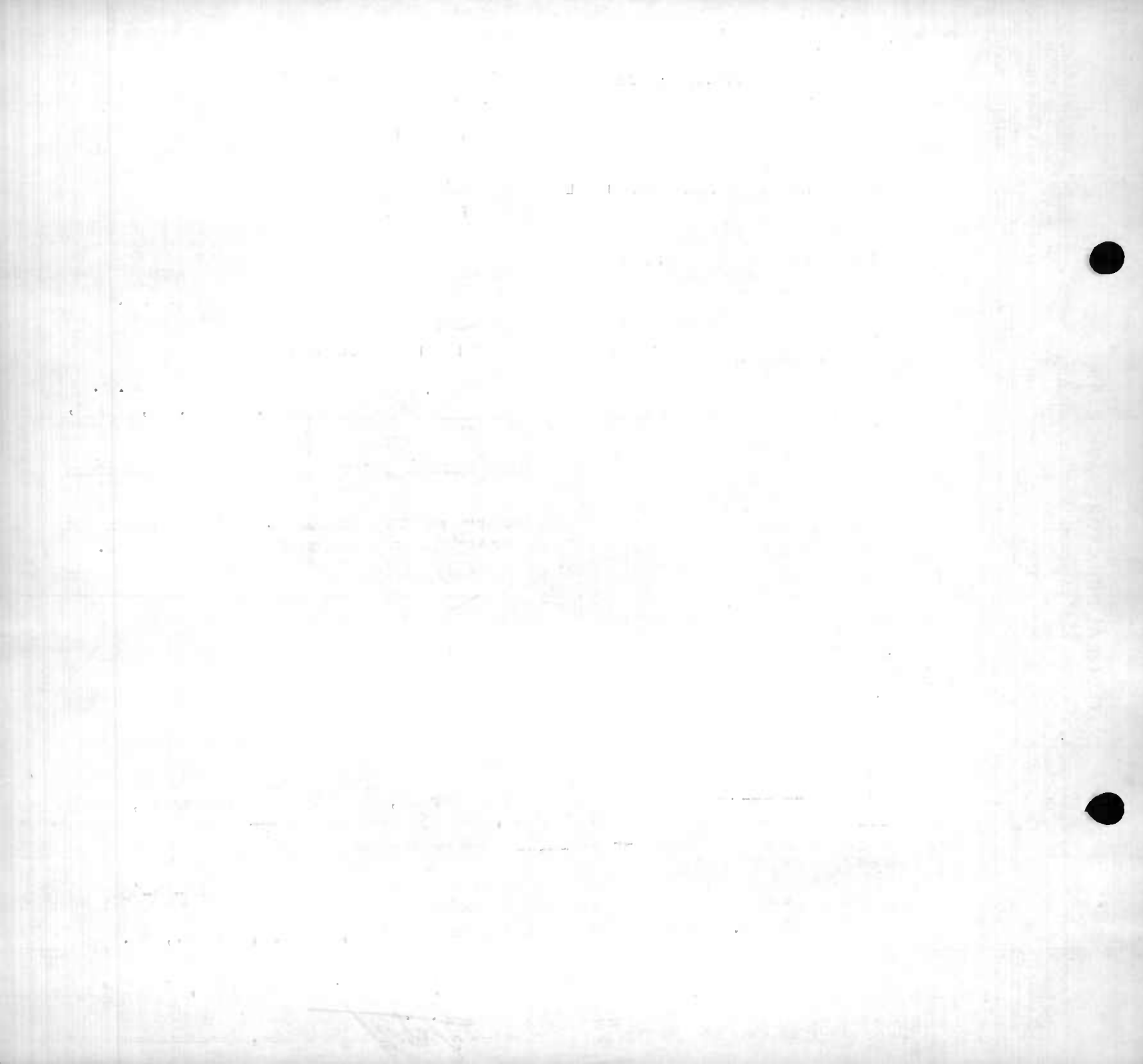
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13220 | |
|---|--------------|--|-------------------------------|---|--|
| BIRTH NO. 65 13220 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ANNA P. REKUS | | 2. DATE AND HOUR OF DEATH 12/24/65 8 a.m. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 18-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 823 Hollins St. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 823 Hollins St - Baltol, Md. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 1/18/1884 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing Co. | | 11. BIRTHPLACE (State or foreign country) Lithuania | |
| 13. FATHER'S NAME Peter ? | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-05-8056 | | 17. INFORMANT Andrew Rekus - 553 Brook Rd. 4 | |
| 18. 420-1-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion | | CAUSE OF DEATH (A) DUE TO A.S.C.U.D. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 56 to Dec, 24 19 65, that (I) (we) last saw the deceased alive on Dec, 24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stanley Ankudars | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12.24.65 | |
| 23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDARS | | 23D. ADDRESS 1802 W. Baltol 21223 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem. | |
| 24D. LOCATION Baltimore, Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR John J. Cowan | | 25C. FUNERAL DIRECTOR John J. Cowan, Inc. 901 Hollins St. Baltol 23, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|---|---|---|---|--|--|--|------------------------------|
| BIRTH NO. 65 13221 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 13221 | | | | |
| 1. NAME OF DECEASED (Type or Print) IRBY, PEACE | | | | | 2. DATE AND HOUR OF DEATH 12-22-65 8:00 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | A. STATE VIRGINIA B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) MANNBORO D. STREET ADDRESS (If rural, give location) Rt 1 Box 94 | | | | |
| 5. SEX FEMALE | | 6. RACE NEGRO | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | | 8. DATE OF BIRTH 60 | | 9. AGE (In years last birthday) 60 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY House work | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME EDWARD JOHNSON | | | | | 14. MOTHER'S MAIDEN NAME WILLIE BELL JOHNSON | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Rebecca Leland 915 Intervale Ave. Apt. 16, Bronx, N.Y. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Intracranial hemorrhage DUE TO (B) Hypertensive arteriosclerotic cerebrovascular disease DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 12 hours several years. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION None | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 22, 1965 to December 22, 1965, that (I) (we) last saw the deceased alive on December 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Jay B. Jensen | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-22-65 |
| 23C. PHYSICIAN'S NAME (Type) Jay B. Jensen | | | | | 23D. ADDRESS M.D. Johns Hopkins Hospital, Balto., Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/65 | | 24C. NAME of CEMETERY or CREMATORY Manassa Hill Church, | | | 24D. LOCATION (City, town, or county) (State) Amelia County, Virginia | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR R. L. B. 2, Jr. | | | 25C. FUNERAL DIRECTOR FUNERAL HOME AMELIA, VIRGINIA | | | | |



45-23-81

M-250

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-------------------------------|--|--|
| BIRTH NO. 65 13222 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13222 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MAUZONE, SAM | | 2. DATE AND HOUR OF DEATH 12-22-65 1 5 ¹⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 759 Linnard Street 21229 | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 2-17-1936 | 9. AGE (In years last birthday) 29 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Jacob Mauzone | | 14. MOTHER'S MAIDEN NAME GERTRUDE MOORE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-28-1362 | | 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | CAUSE OF DEATH (A) Metastatic Carcinoma DUE TO of the Colon. (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 7 mos | |
| 19A. DATE OF OPERATION JULY 65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SAME | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-18-65 to 12-22-65, that (I) (we) last saw the deceased alive on 12-22-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Patrick Caulfield | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-22-65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. J. Patrick Caulfield | | 23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 12-27-1965 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery | |
| 24D. LOCATION Annapolis Ave & Hollins Ferry Road, Baltimore, Maryland | | (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR R. A. J. [unclear] | | 25C. FUNERAL DIRECTOR Charles W. Hill 1317 W. North Ave, Baltimore, Maryland | |

letter from hosp. to ~~ch~~ add ~~1/2~~ parent's names. C. B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13223 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13223 | | | |
|--|----------------------|--|--|--|---|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Felix J. Zampini | | | | 2. DATE AND HOUR OF DEATH 12/24/65 11:55 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | A. STATE MD. B. COUNTY 26-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND General Hospital 827 Linden Ave. 21201 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | D. STREET ADDRESS (If rural, give location) 4536 Shamrock Ave. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 1-1-18 | 9. AGE (In years last birthday) 47 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | | 10B. KIND OF BUSINESS OR INDUSTRY State Roads Comm. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Nicholas Zampini | | | | 14. MOTHER'S MAIDEN NAME Katherine Anderson | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Chart | | ADDRESS | | | |
| 18. 330X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES | | | | (A) DUE TO Subarachnoid and intracerebral hemorrhage | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO Rheumatic aortic Valvulitis | | | | | | | |
| | | | | (C) Calcific aortic valve | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/27 19 65 to 12/24 19 65 , that (I) (we) lost saw the deceased alive on 12/24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE John M. Steffy M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/24/65 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) John M. Steffy | | | | 23D. ADDRESS 827 Linden Ave 21201 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1228-65 | | 24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CEM. | | 24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD, BALTO., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert J. Steffy | | 25C. FUNERAL DIRECTOR Charles Steffy | | ADDRESS 901 S. CONKLING ST, BALTO., MD. | | | | | |

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| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---|-----------|--|------------------|---|--|--|--|
| 65 13224 | | | | | | 65 13224 | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| MARTHA E. SKINNER | | | | 24 December 1965 3:05 p. m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| Baltimore City Hospitals | | | | A. STATE Maryland B. COUNTY Balt | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| Baltimore City Hospitals | | | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 2011 Brandt Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| female | caucasian | widowed | Sept. 22, 1892 | 73 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| nurses aid | | state hospitals | | York, Penna. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| James Ferguson | | | | unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| no | | 371-32-6605 | | Charles Reese, Baltimore, Md. | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Pulmonary Embolus | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) Traumatic Injuries of Brain, Brain Stem, Spine and Pelvis. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | Street | | Old Eastern Avenue & Mars Road, Essex | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| 9 5 '65 A | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Passenger in auto-auto collision. | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | M.D. | | DATE SIGNED | |
| Charles S. Petty | | Charles S. Petty | | | | 12/25/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| burial | | 12-28-65 | | Rest Haven Cemetery | | Hagerstown, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 28 1965 | | R. L. A. E. Jones | | Scott F. Minnich & Son, Hag., Md. | | | |

WALTER H. HIGHT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13225 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13225 | |
|--|-------------------------|--|--|--|-----------------------------|--|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MILLICENT M. BOYER | | | | 2. DATE AND HOUR OF DEATH DECEMBER 23, 1965 5. A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1213 WASHINGTON BOULEVARD 21230 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) 1213 WASHINGTON BLVD. 21230 | | | | E. CITY OR TOWN (If rural, give location) 2102 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH OCTOBER 25/84 | 9. AGE (In years last birthday) 81 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT ADDRESS XXXXXXXX MR. IRVIN E. BOYER, 1213 WASHINGTON BLVD. | |
| 18. 170 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma left breast | | | | CAUSE OF DEATH 7 years | | | |
| 19. 0 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH 7 years | | | |
| 20. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 11/11 19 53 to 12/23 19 65 , that (I) (we) last saw the deceased alive on 12/22 19 65 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John P. Urlock Jr. | | | | 23B. DATE SIGNED Dec 24, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR. | | | | 23D. ADDRESS 1227 WASHINGTON BLVD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/27/65 | | 24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Ireland | | 25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13226 | | REGISTERED NO. 65 13226 | |
|---|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) ZORA T. MARTIN | | | | 2. DATE AND HOUR OF DEATH DECEMBER 23, 1965 6:00P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-08 | | | |
| 5. SEX M FEMALE | | | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME RICHARD A. FERERLINE | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH DUNN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT ST. AGNES RECORDS WILKENS AND CATON MR. WILLIAM M. MARTIN, 584 BEECHFIELD AVE. | |
| 18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Cerebro Vascular Accident - Lt hemiplegia DUE TO (B) Complete A-V Block - Ventricles controlled by artificial pacemaker. DUE TO (C) ASCVD | | INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 13 1965 to DECEMBER 23 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 23 1965 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (<input checked="" type="checkbox"/> (We) (did) (<input checked="" type="checkbox"/> and not) view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) DR EWALDO WEISS | | | | 23D. ADDRESS M.O. ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/27/65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13227 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13227 | |
|---|-------------------------|---|---|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HARRY BOSS | | | | 2. DATE AND HOUR OF DEATH Dec 22, 1965 5 p. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 5106 Ardmore Way | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH APRIL 23, 1893 | | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HATTER | | 10B. KIND OF BUSINESS OR INDUSTRY MEN'S HATS, INC. | | 11. BIRTHPLACE (State or foreign country) BALTO., MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME WILLIAM BOSS | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212-09-0485 | | 17. INFORMANT WIFE | | ADDRESS 5106 ARDMORE WAY | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 6 Hours. | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Albert J. Himelfarb | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) ALBERT J. HIMELFARB | | | | 23D. ADDRESS M.D. 3501 ST. PAUL ST. BALTIMORE MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-27-65 | | 24C. NAME of CEMETERY or PROPERTY PARKWOOD CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR John A. Jones | | 25C. FUNERAL DIRECTOR J. Walter Conklin | | ADDRESS 5444 BELAIR RD | |

THE WHITE HOUSE
WASHINGTON
JAN 21 1900

DEAR MR. TOWN
I have just received your letter of the 19th inst.

and am glad to hear that you are interested in the
work of the Department.

I am sure that you will find the information
which you desire.

I am, very respectfully,
Yours,
J. E. Townsend

Enclosed for you are the
reports of the Department for the year 1899.

I am, very respectfully,
Yours,
J. E. Townsend

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65-13228 | |
|--|---|--|---|--|---|
| BIRTH NO. 65-13228718 | | CERTIFICATE OF DEATH | | 12/24/65 9 P.M. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>SMITH, JULIUS EICK, Julius</i> | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE <i>MD.</i> B. COUNTY <i>27-19</i> | |
| FULL NAME OF (If not in hospital or institution, give street address or location) <i>Sinac Hosp 1/12/66</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>5710 Narcissus Ave</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>7/21/1900</i> | 9. AGE (In years last birthday) <i>65</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Clerk</i> | 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>ELIAS SMITH</i> | | 14. MOTHER'S MAIDEN NAME <i>MARTHA SAHINGER</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <i>159-26-5199</i> | | 17. INFORMANT <i>JOHN EICK</i> | | ADDRESS <i>3706 Kingswood Square</i> | |
| 18. <i>420.11</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) DUE TO <i>Myocardial infarction</i> | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO <i>ASCVD</i> | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that <i>he</i> (this hospital) attended the deceased from <i>12/6/65</i> 19 <i>65</i> to <i>12/24</i> 19 <i>65</i> , that <i>(I)</i> (we) last saw the deceased alive on <i>12/24</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Leonard J. Heitzberg</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-24-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Leonard J. Heitzberg</i> | | M.D. ADDRESS <i>Sinac Hosp</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>12/24/65</i> | 24C. NAME OF CEMETERY or CREMATORY <i>CHURCH ANNAVAS CHESED INC.</i> | 24D. LOCATION (City, town, or county) (State) <i>RANDALLSTOWN MD.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | 25B. NAME OF REGISTRAR <i>DEC 28 1965</i> | 25C. FUNERAL DIRECTOR <i>Jack Levine INC.</i> | | ADDRESS <i>2100 Eutaw Place BALTO. CITY MD.</i> | |

vs 153 1/12/66

C.B.

FUNERAL DIRECTOR: IMPORTANT

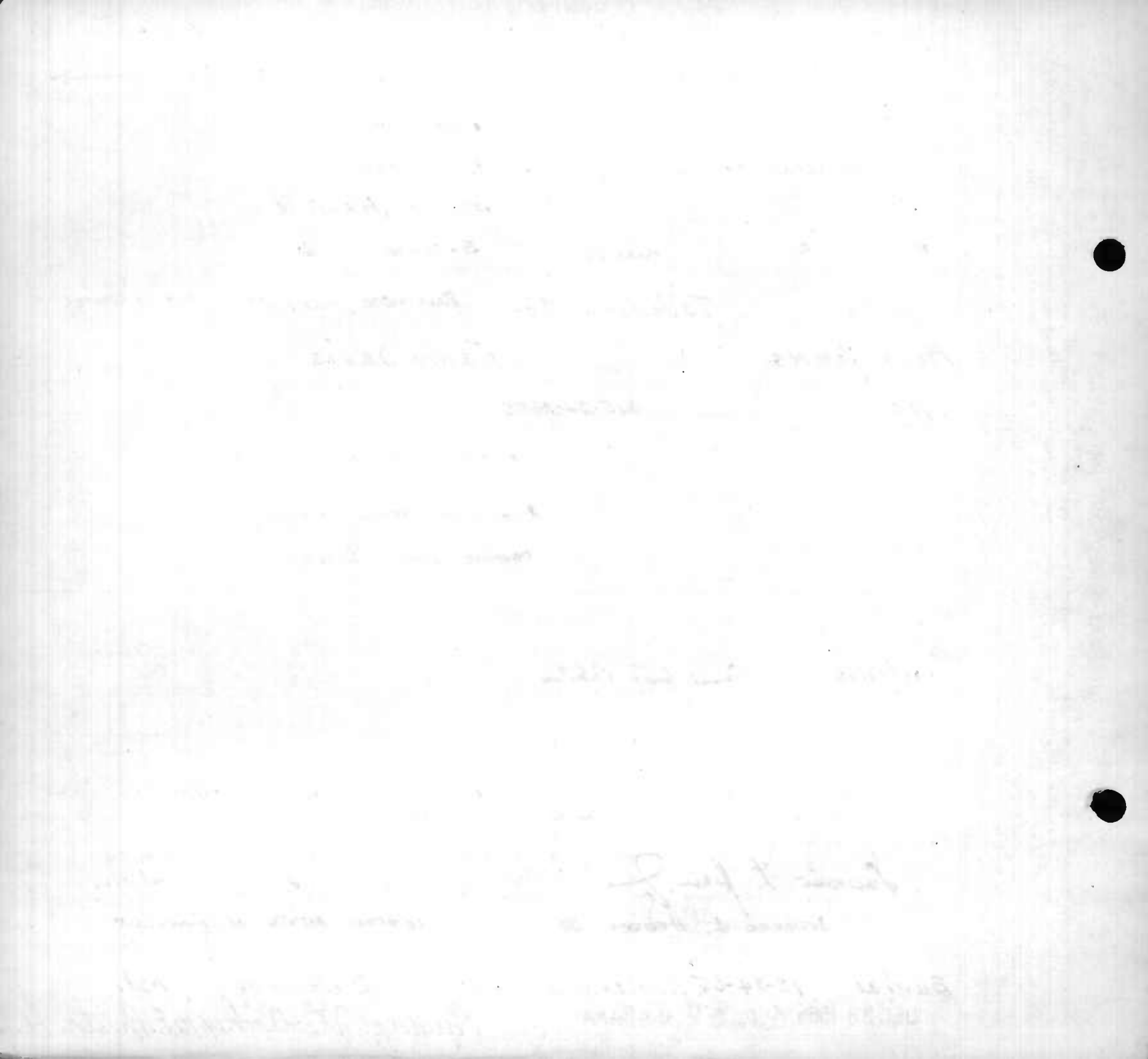
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| BIRTH NO. 65 13229 | | CERTIFICATE OF DEATH | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13229 | |
| M.E. CASE NO. EDNA PERCY | | | | 2. DATE AND HOUR OF DEATH DEC. 23 1965 7:30 AM. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| 36 FRANKLIN SQUARE HOSPITAL | | | | MD DUNDALK Baltr | | | |
| 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | | | | 8. DATE OF BIRTH 6/26/00 9. AGE (In years last birthday) 65 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| HOUSEWIFE | | | | PENN. | | | |
| 13. FATHER'S NAME SIMON SILVERMAN | | | | 14. MOTHER'S MAIDEN NAME JENNIE PATZ | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 216-14-0550 | | | |
| 17. INFORMANT RUTH PERCY SMITH | | | | ADDRESS 8107 LONGPOINT RD. | | | |
| 18. 4201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH MYOCARDIAL INFARCTION | | | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from NOV. 30 1965 to DEC. 23 1965 , that (I) (we) last saw the deceased alive on DEC. 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Wilfredo M. Mediano M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-23-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) WILFREDO M. MEDIANO M.D. | | | | 23D. ADDRESS FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY MT. CARMEL GERMAN HILL RD. DUNDALK MD. | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert G. Jenkins | | 25C. FUNERAL DIRECTOR Jack Lewis Inc. 2100 EUTAW PL. | | ADDRESS BALTIMORE CITY MD. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

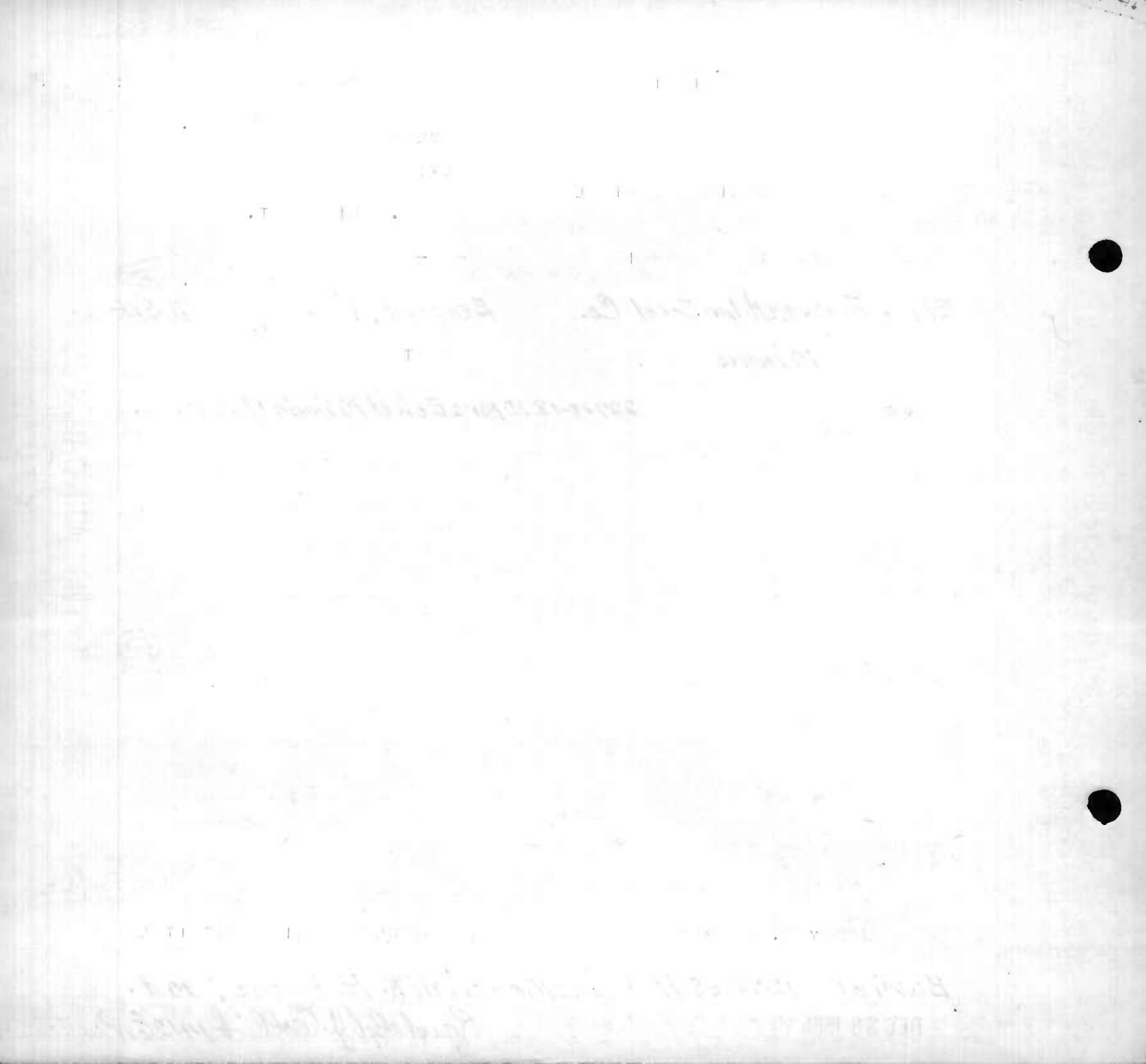
| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. 65 13230 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13230 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MURALENE BELL | | 2. DATE AND HOUR OF DEATH 12/22/65 8:20 pm → M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2305 E. Federal St | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3-3-24 | 9. AGE (In years lost birthday) 41 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid | | 10B. KIND OF BUSINESS OR INDUSTRY Tailoring Co. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 13. FATHER'S NAME Alex Young | | 14. MOTHER'S MAIDEN NAME Janie Davis | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-24-2653 | | 17. INFORMANT Chart | |
| 18. 5-27-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) ACUTE PULMONARY EDEMA DUE TO (B) RIGHT-SIDED HEART FAILURE DUE TO (C) CHRONIC LUNG DISEASE | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 1/12/18/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel Obstruction | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/17 19 65 to 12/20 19 65 , that (I) (we) lost saw the deceased alive on 12/20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Desiderio L. Hebron, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) DESIDERIO L. HEBRON, JR. | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY or CREMATORY National Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Randolph Collick | | ADDRESS 1412 E. Preston St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|---|---|--|--|
| 65 13231 | | 65 13231 | | 65 13231 | |
| <div> <div>1. NAME OF DECEASED</div> <div>(Type or Print)</div> <div>EDWARD MINNIS</div> </div> <div> <div>2. DATE AND HOUR OF DEATH</div> <div>12-24-65</div> <div>3:00 P.M.</div> </div> | | | | | |
| <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> <div>THE JOHNS HOPKINS HOSPITAL</div> </div> | | | <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE</div> <div>B. COUNTY</div> <div>MARYLAND</div> </div> <div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</div> <div>BALTIMORE</div> </div> <div> <div>D. STREET ADDRESS (If rural, give location)</div> <div>1733 E. OLIVER ST.</div> </div> | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | <div>If Under 1 Yr.</div> <div>Months: Days: Hours: Min.</div> |
| MALE | NEGROID | MARRIED | 6-20-18 | 47 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Blast Furnace Helper Steel Co. | | | | Bedford, Va. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| EDWARD MINNIS | | | ROBERTA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 227-0-1870 Mrs Ethel Minnis | | 1733 E. Oliver St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | (A) Carcinoma left Lung | | |
| <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> | | | <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>Symptomatic for 2 months</div> | | |
| <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> | | | Diabetes mellitus | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 3 12/21/65 | | Carcinoma left lung | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., home, farm, factory, street, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from 12/9 1965 to 12/24 1965, that (I) lost saw the deceased alive on 12/24 3PM 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
|  | | | | 12/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| JERRY S. DORMAN | | | | THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12-28-65 | | Arbutus Memorial PK. Arbutus, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 28 1965 | | R. E. 2, Jackson | | Randolph Collick 1412 E. Preston St. | |



L-600

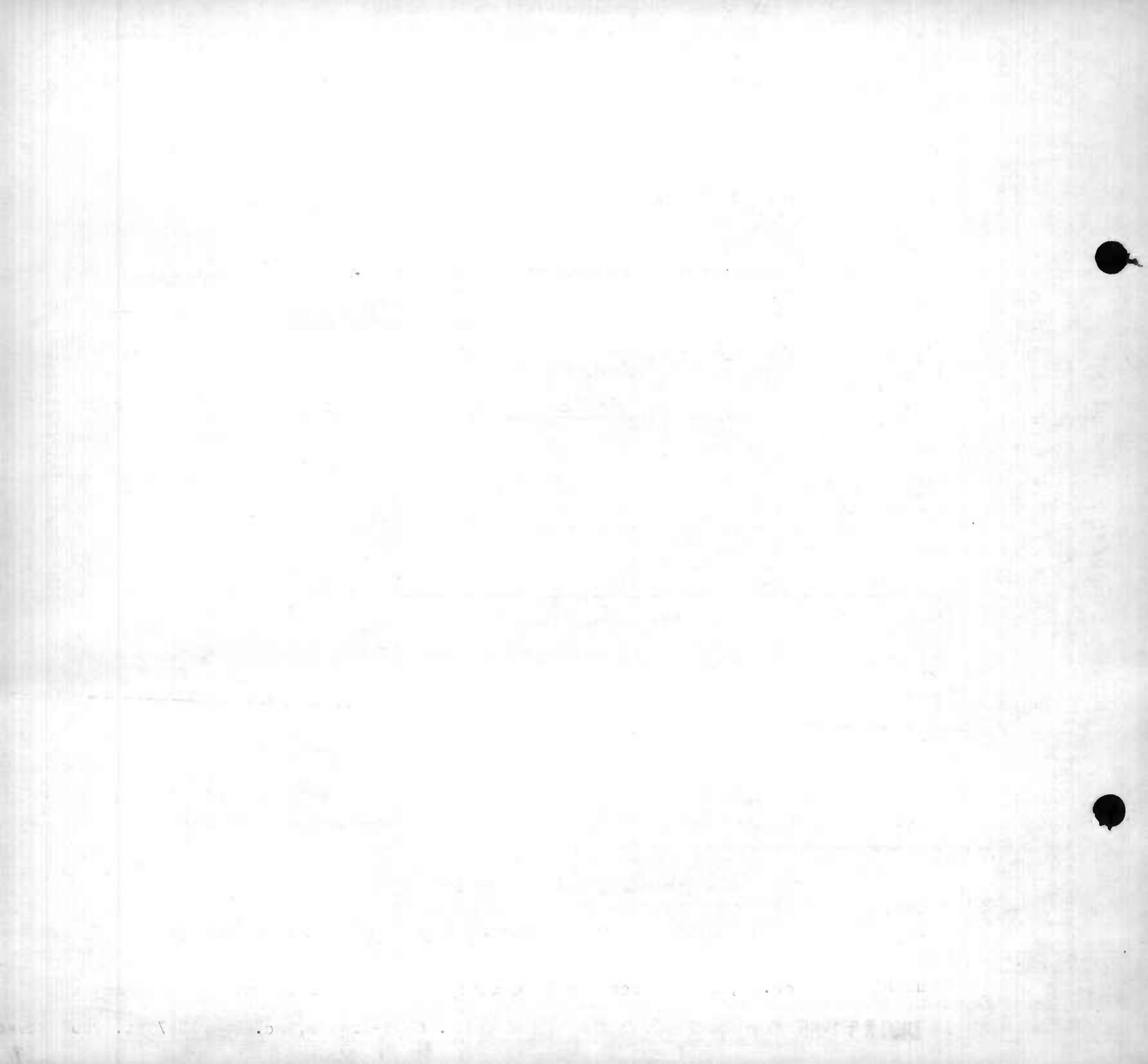
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 13232 | | | |
|---|---------|--|------------------|---|---|--|--|
| BIRTH NO. 65 13232 | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____ | | | |
| M.E. CASE NO. _____ | | | | _____ | | | |
| 1. NAME OF DECEASED (Type or Print) | | LAWRENCE B. LEARY | | 2. DATE AND HOUR PRONOUNCED DEAD | | December 23, 1965 3:55 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE Maryland B. COUNTY Baltimore | | | |
| Baltimore City Hospitals | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 7809 Eastdale Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| Male | White | Widowed | 2/27/1880 | 85 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Coal | | Daniel Miller Coal | | Baltimore, Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Peter Lyra | | | | Rebecca Horton | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | Emma Lyra 7809 Eastdale Rd. | | 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| 422.14-E812.4 | | | | (A) Congestive Heart Failure | | | |
| DUE TO | | | | (B) Arteriosclerotic Cardiovascular Disease. | | | |
| DUE TO | | | | (C) _____ | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Multiple Traumatic Injuries. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | Street | | Overpass Eastern Blvd., E. of North Point Blvd./ | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Pedestrian struck by auto. | | | |
| 12 10 '65 P | | | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 12/23/65 | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/27/65 | | Lorraine Park Cemetery | | Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 28 1965 | | Robert E. Jenkins | | Wm. Cook-Books Inc. 1217 St. Paul St. | | 21202 | |

VALLEY
FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13233 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13233 | |
|---|---------------------|---|--|--|--|---|--|-----------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) MARIE W. BROWN | | 2. DATE AND HOUR OF DEATH 12.26.65 7 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 10-01 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Little Sisters of the Poor 1200 VALLEY ST. BALTIMORE MD | | | | D. STREET ADDRESS (If rural, give location) 1200 Valley St | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 11.18.1874 | 9. AGE (In years last birthday) 91 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House WORK | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore MD | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME James R. BROWN | | | | 14. MOTHER'S MAIDEN NAME PALMYRE WARRINGTON | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Little Sisters of The Poor | | ADDRESS | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Massive myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| MEDICAL CERTIFICATION | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to 12.26 19 65 , that (I) (we) last saw the deceased alive on 12.26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Stanley Ankudas | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12.27.65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Stanley Ankudas | | M.D. | | 23D. ADDRESS 1802 W Baltimore St. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 28, 65 | | 24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. | | ADDRESS 1217 St. Paul Street | | | |



BIRTH NO. **65 13234** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 13234**

M.E. CASE NO.

| | | | | | |
|---|------------------|---|--|--|---------------------------------------|
| 1. NAME OF DECEASED (Type or Print) | | ESTELLA STELLA BECK | | 2. DATE AND HOUR PRONOUNCED DEAD December 26, 1965 10:50A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 800 Streeper Street | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single | | 8. DATE OF BIRTH Aug. 3, 1890 | 9. AGE (In years last birthday) 75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Char-lady | | 10B. KIND OF BUSINESS OR INDUSTRY Home to Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME William Beck | | | | 14. MOTHER'S MAIDEN NAME Mary C. Case | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-36-8731 | | 17. INFORMANT Vernon Beck, Jr., 1160 Northern Pkwy | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, lorn, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/29/65 | | 23C. NAME of CEMETERY or CREMATORY Baltimore Cemetery | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 24B. NAME OF REGISTRAR R. S. Fisher, M.D. | | 24C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St. | |
| 23D. LOCATION (City, town, or county) | | Baltimore, Md. | | 1 State <input checked="" type="checkbox"/> | |

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 13235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13235

M.E. CASE NO.

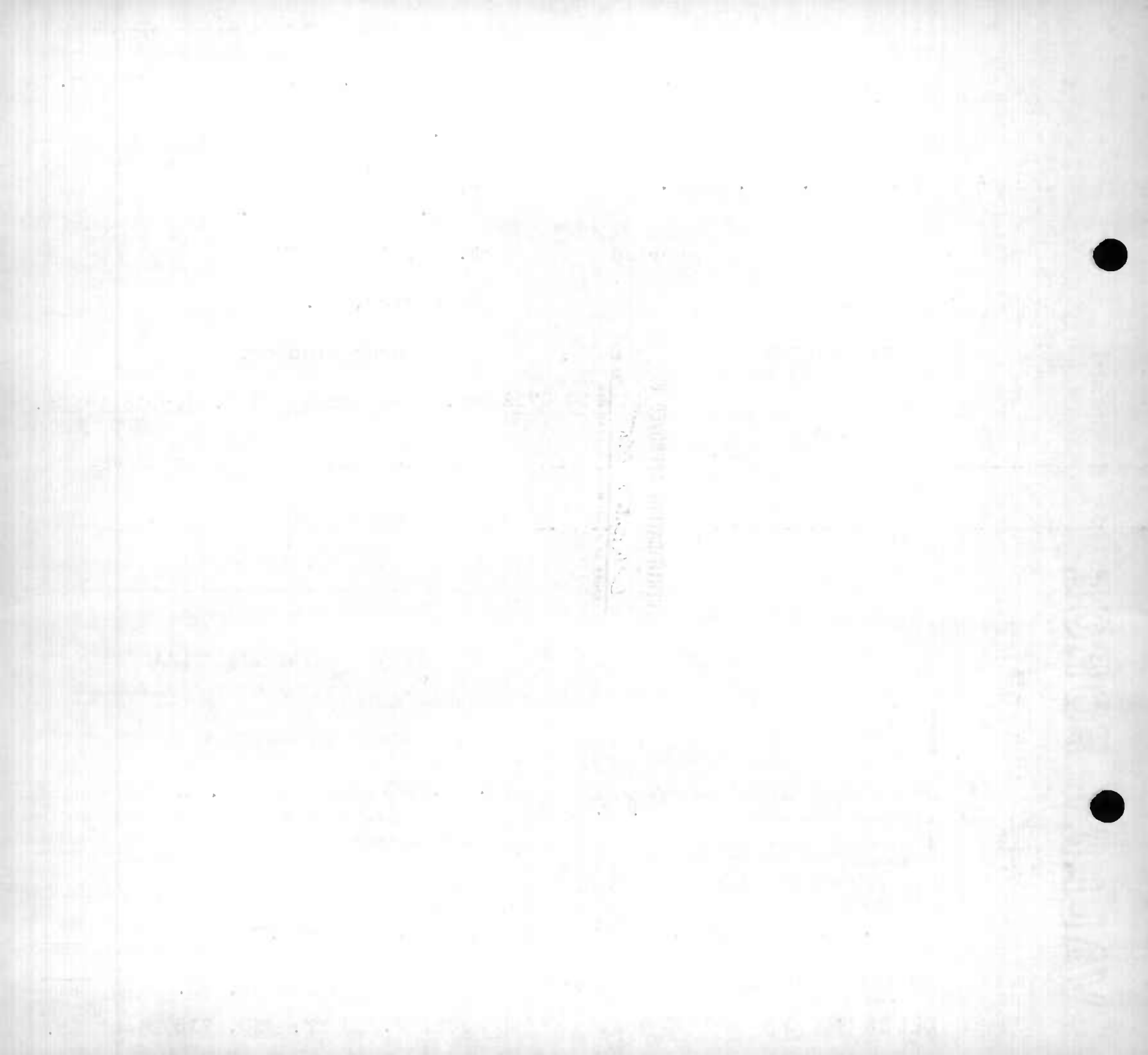
| | | | |
|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) Catherine ANNA GILLESPIE | | 2. DATE AND HOUR PRONOUNCED DEAD 26 December 1965 9:45 a. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2527 Ashland Ave. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2527 Ashland Ave. | |
| 5. SEX female | 6. RACE caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Sept. 23, 1919 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Sale Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Catspaw Rubber Heel | 11. BIRTHPLACE (State or foreign country) Co. Baltimore, Md. |
| 13. FATHER'S NAME Edward Shea | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 218-18-6401 | 17. INFORMANT ADDRESS Richard V. Gillespie, husband, above |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Nephritis. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/29/65 | 23C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 24B. NAME OF REGISTRAR J. J. [unclear] | 24C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601-03-05 E. Madison Street #5 |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. ADDRESS #5 | |

WALL STREET JOURNAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

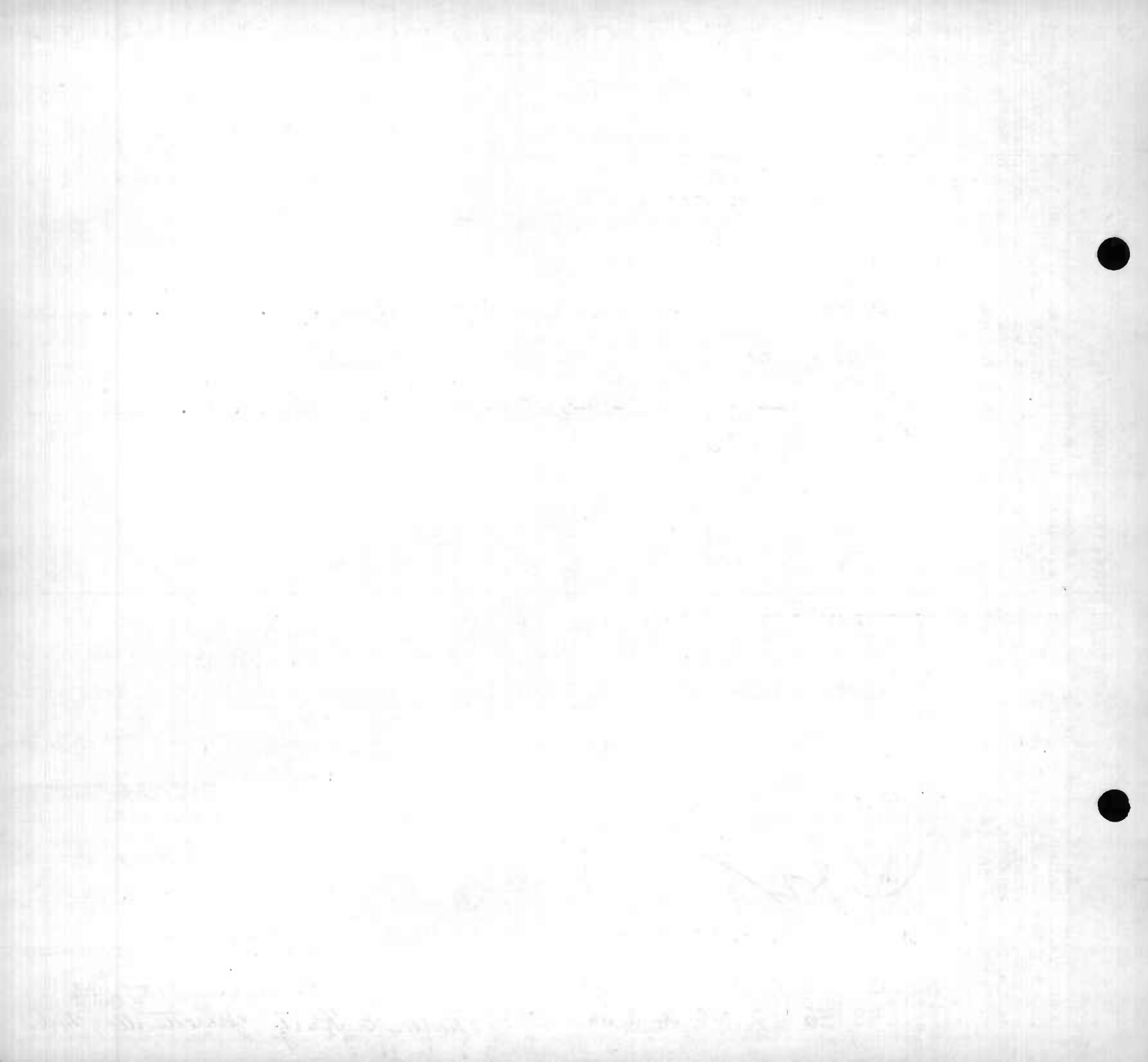
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--------------|---|----------------------------------|--|---|
| 65 13236 | | CERTIFICATE OF DEATH | | 65 13236 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | CLARENCE V. MORGAN | | 2. DATE AND HOUR OF DEATH Dec. 24, 1965 4:15 p. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. | | | |
| 3 SO. Balto. Gen. Hosp. | | B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 9 E. Henrietta St. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Oct. 11, '88 | 9. AGE (In years last birthday) 77 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Frederick, Md. | |
| 13. FATHER'S NAME Scott Morgan | | 14. MOTHER'S MAIDEN NAME Sarah Plunkert | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 210-10 0712 | | 17. INFORMANT Mrs. Mary Morgan 9 E. Henrietta St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1 | | CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO | | INTERVAL BETWEEN ONSET AND DEATH Immediate | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Hypertensive cardio vascular disease DUE TO | | 2 - 3 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 28, 1963 19 to Dec. 24, 1965 19, that (I) (we) last saw the deceased alive on Dec. 20, 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry Deibel M.D. | | | | 23B. DATE SIGNED 12/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Harry Deibel | | 23D. ADDRESS M.D. 1226 S. Hanover Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR John F. Denny | | 25C. FUNERAL DIRECTOR JOHN F. DENNY, INC. 715 Light St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

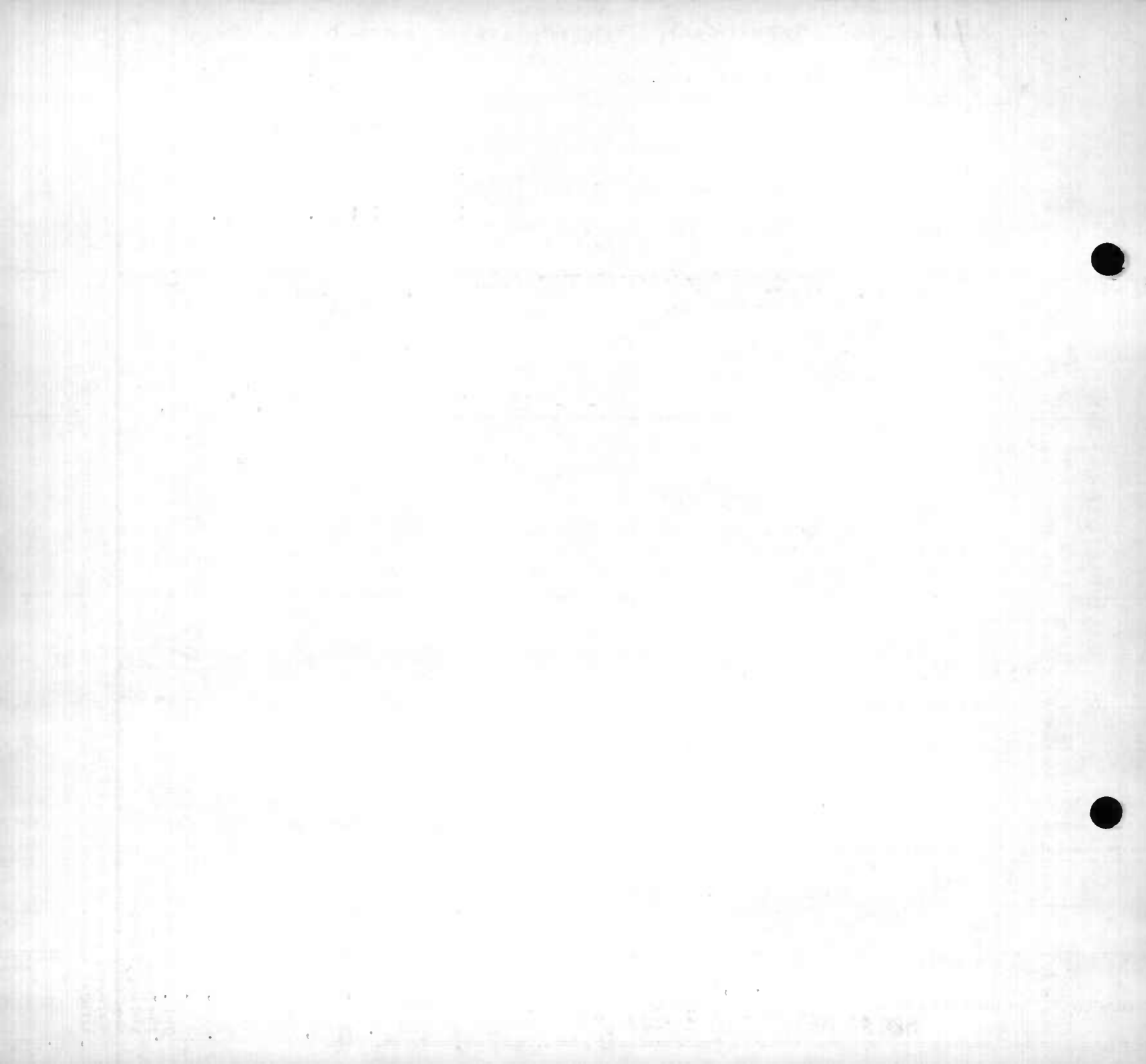
| BIRTH NO. 65 13237 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13237 | |
|--|--|--|--|---|--|--|--|--------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | Amos, Thomas Henry | | 12/24/65 | | 8:40 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | | | |
| Provident Hospital 1514 Division Street | | | | Maryland Baltimore City | | | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | Baltimore City | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 1106 Harlem Avenue | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Male | | Negro | | Widower | | 2/13/1870 | | 95 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Laborer | | Farm | | Jarrettsville, Md. | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| James Amos | | | | Mary Hall | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No --- | | | | 218-18-5926 | | Gertrude Amos | | 1106 Harlem Ave. Balto. Md. 21217 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Uremia | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | |
| II | | | | Old Age | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/24/1965 to 12/24/1965, that (I) (we) last saw the deceased alive on 12/24/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED | |
| | | | | | | | | 12/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| V. S. Rao | | | | PROVIDENT HOSPITAL, INC. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 12/28/65 | | Fairview | | Forest Hill, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| DEC 28 1965 | | Robert E. Jarrett | | Charles E. Kurtz | | Jarrettsville, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|---|--|---|
| BIRTH NO. 65 13238 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13238 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BLAND (n) Simp Kinn | | 2. DATE AND HOUR OF DEATH 12/24/60 12 27 pm | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE NEW YORK B. COUNTY V-29 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 South Bkto. Genl. Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) JAMAICA | | | |
| | | D. STREET ADDRESS (If rural, give location) 108 33 171 st. Place St. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M. | 8. DATE OF BIRTH 2/24/22 | 9. AGE (In years last birthday) 43 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Steward | | 10B. KIND OF BUSINESS OR INDUSTRY FRANKLIN McGraw | | 11. BIRTHPLACE (State or foreign country) Aiken, South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME BUSTER SIMKINS | | 14. MOTHER'S MAIDEN NAME SYLVIA WATKINS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 247-24-4015 | | 17. INFORMANT ADDRESS 17924 Linden Ave Phillips Funeral Home, Jamaica, New York | |
| 18. 24 IX I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) BRONCHIAL ASTHMA DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>it</u> (this hospital) attended the deceased from 12/24/60 19 to 12/24/60 19, that <u>it</u> (we) last saw the deceased alive on 12/24/60 19 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald C. Roane | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) DONALD C. ROANE | | M.D. Staff | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE Dec. 29, 1965 | | 24C. NAME OF CEMETERY or CREMATORY LONG ISLAND NATIONAL CEMETERY, Farmingdale, L.I., New York | |
| 24D. LOCATION (City, town, or county) (State) New York | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Harold S. Wade | |
| 25C. FUNERAL DIRECTOR ADDRESS 550 Wash. Blvd. Laurel, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

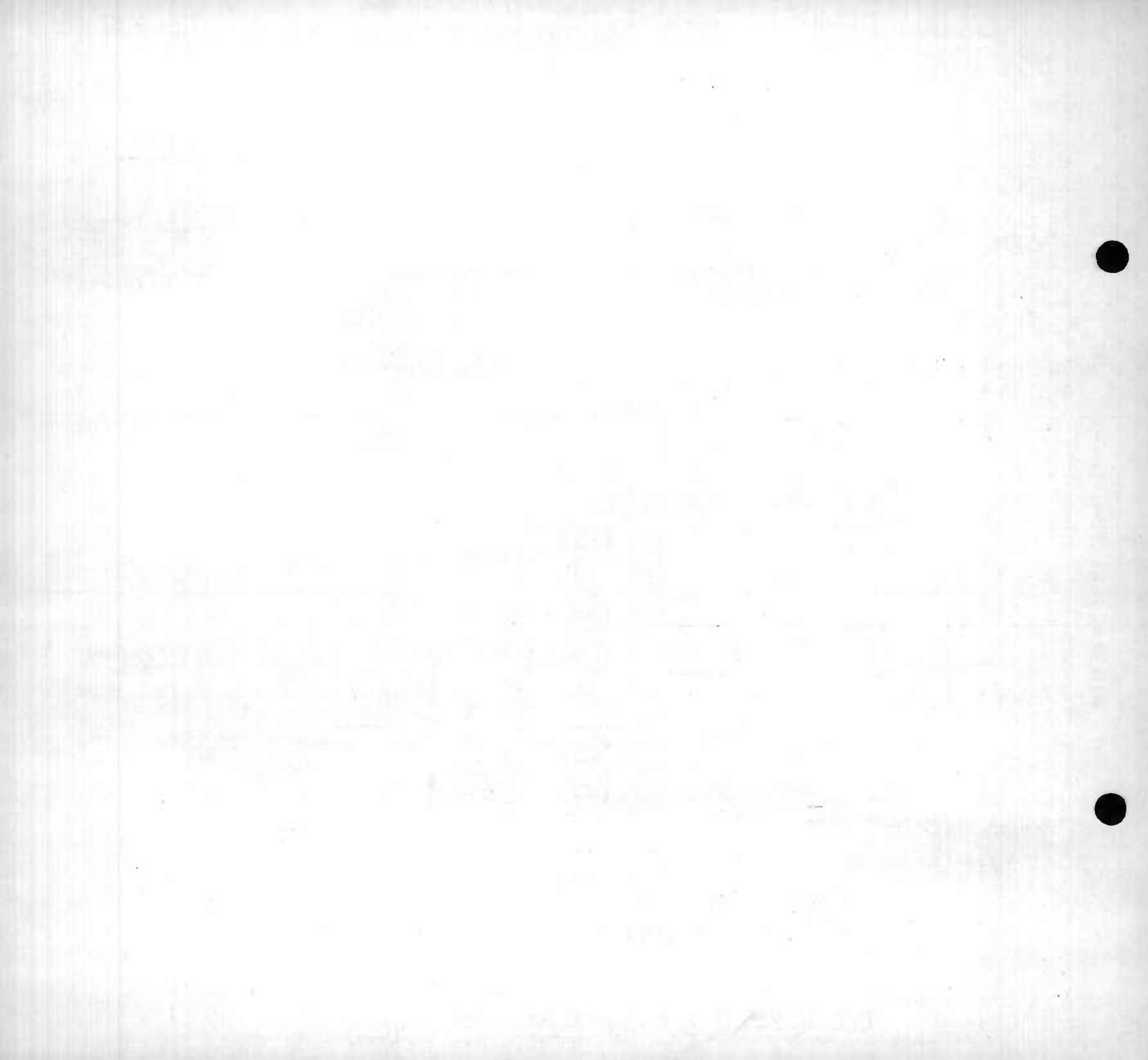
| BIRTH NO. 65 13239 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13239 | |
|---|------------------|---|-----------------------------------|--|---|--|------------------------------|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH 12-23-65 8:30 PM. | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Wilson | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | | D. STREET ADDRESS (If rural, give location) 626 East Eager Street | | 10-01 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 12-23-65 | 9. AGE (In years last birthday) 12-23-65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Samuel Robinson | | | | 14. MOTHER'S MAIDEN NAME Catherine Wilson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH (A) Immaturity DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 8½ hours | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-23-19 65 to 12-23-19 65, that (I) (we) last saw the deceased alive on 12-23-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Nicholas J. Criares</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) Nicholas J. Criares | | | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | | 24B. DATE 12-24-65 | | 24C. NAME OF CEMETERY or CREMATORY John Hopkins Hospital | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS | | | |

To Mr Boul
B V Boul
Ourselves

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

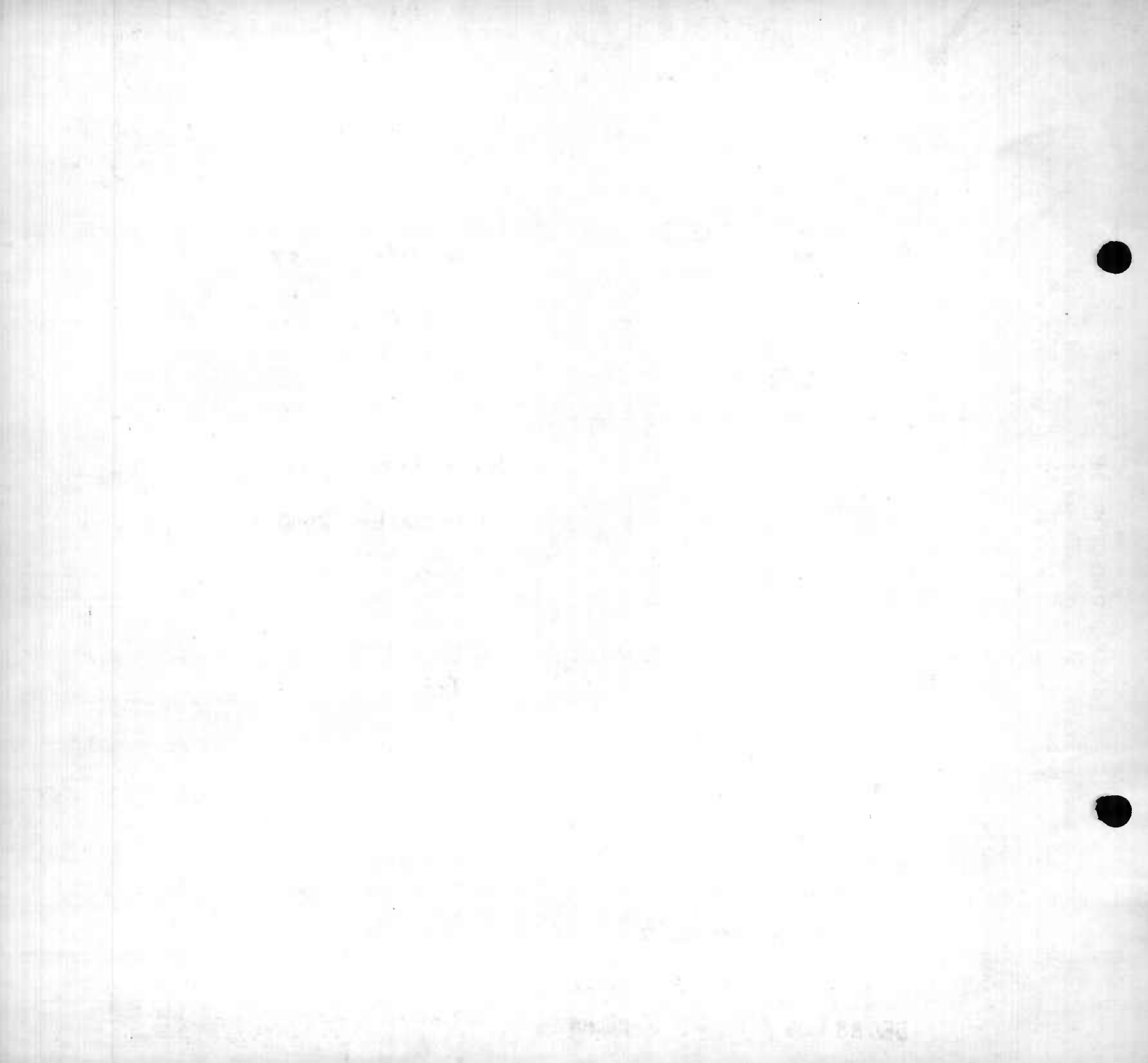
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13240 | |
|--|---------------------------|--|--|--|---|
| BIRTH NO. 65 13240 65 31498 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Morgan, Baby Girl | | | 2. DATE AND HOUR OF DEATH 12-24-65 7:10 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 835 North Wolfe Street | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) Never Married | 8. DATE OF BIRTH 12-15-65 | 9. AGE (In years last birthday) 9 | If Under 1 Yr. Months: 9 Days: 05 Hours: 10 Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME James Morgan | | | 14. MOTHER'S MAIDEN NAME Lottie Williams | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia DUE TO 6 days | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hyaline Membrane Disease DUE TO 8 days | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity DUE TO 8 days | | | | | |
| 19A. DATE OF OPERATION 2 ----- | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-15 19 65 to 12-24 19 65 , that (I) (we) last saw the deceased alive on 12-24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jerry A. Winkelstein | | | | 23B. DATE SIGNED 12-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) Jerry A. Winkelstein | | | 23D. ADDRESS The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | 24B. DATE 12-25 | 24C. NAME of CEMETERY or CREMATORY Johns Hopkins Hospital | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Staley, M.D. | 25C. FUNERAL DIRECTOR ADDRESS 1 8 5 0 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|-------------------------------------|---|--|
| BIRTH NO. 65 13241 | | CERTIFICATE OF DEATH | | Registered No. 65 13241 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Ruszin, Mildred M | | 2. DATE AND HOUR OF DEATH 12/26/65 7:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE B. COUNTY MD | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 1931 CHURCH ROAD 21222 5300 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 01-14-28 | 9. AGE (In years last birthday) 37 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME MICHAEL SZPATURA | | 14. MOTHER'S MAIDEN NAME JASTINE REGULA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS PAUL H. RUSZIN 1931 CHURCH RD | |
| 18. 58101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hepatocellular insufficiency ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic active hepatitis | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 4 weeks 1 year | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) this hospital attended the deceased from 12/24/65 19 65 to 12/26 19 65 , that (I) (we) last saw the deceased alive on 12/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Philip Horowitz | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) PHILIP HOROWITZ Philip Horowitz | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY ST. MICHAEL UKRAINE CEM | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE Co MD | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS JOHN M. WEBER & SONS INC 401 S. CHESTER ST. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-----------------------------|--|--|
| BIRTH NO. 65 13242 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13242 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) STROMBERG, JANE H. | | 2. DATE AND HOUR OF DEATH 12-25-65 2:15A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELICOTT CITY 63-00 D. STREET ADDRESS (If rural, give location) ROGERS AVE. 142 North | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8-25-90 | 9. AGE (In years lost birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME EZEKIAL MOXLEY | | 14. MOTHER'S MAIDEN NAME EMMA MILLER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ST. AGNES RECORDS-CATON & WILKENS AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CENTRAL ENCEPHALITIS | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 17 19 65 DECEMBER 25 19 65 that (I) (we) last saw the deceased alive on DECEMBER 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE PEDRO P. PURCELL M.D. | | | | 23B. DATE SIGNED Dec 25-1965 | |
| 23C. PHYSICIAN'S NAME (Type) PEDRO P. PURCELL M.D. | | 23D. ADDRESS M.D. CATON & WILKENS AVES. BALTO.#29, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 28, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Good Shepherd | |
| 24D. LOCATION Ellicott City, MD | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR F. C. Higginbotham | |
| 25D. ADDRESS Ellicott City, MD | | | | | |

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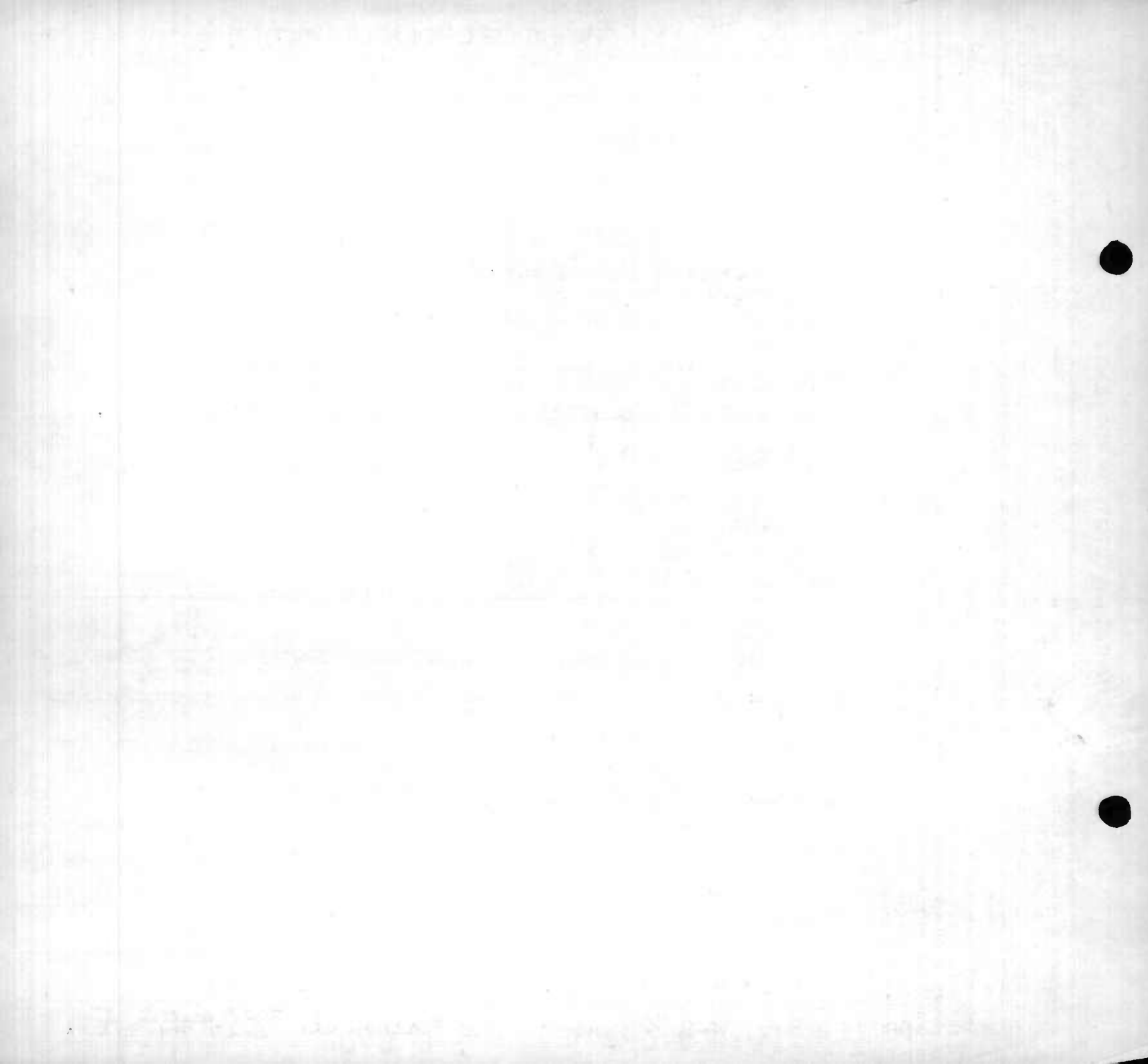
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13243 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13243 | |
|---|-----------|--|------------------|---|-----------------------|--|----------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) JOSEPH L. STEEN | | | | 12-25-65 | | 4:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| CHURCH HOME & HOSPITAL | | | | MD. | | 3-01 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 514 S. BOND ST | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 4 Hrs. Min. |
| M | W | MARRIED | 9-30-97 | 68 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| RETIRED | | MD. HOUSE OF CORRECTION | | PENNA. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JOSEPH STEEN | | | | ELIZABETH RICHEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| YES. WWI 1917-1919 | | 215-18-8815 | | IDA STEEN | | 514 S. BOND ST. BALTO. MD. 21231 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) SEVERE PNEUMONIA | | | |
| ANTECEDENT CAUSES | | | | DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | MARKED EMPHYSEMA | | | |
| | | | | (B) SE | | | |
| | | | | (C) OLD CEREBRO-VASCULAR | | | |
| | | | | ACCIDENT; SEVERE MALNUTRITION | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| O | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-23 19 65 to 12-25 19 65, that (I) (we) last saw the deceased alive on 12-25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Ephraim B. Barzaga | | | | | | 12-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Ephraim B. BARZAGA | | | | CHURCH HOME & HOSP - BALTO-31, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | 12-29-65 | Balto. Nat'l. Cem. | | Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 28 1965 | | Robert E. J. J. J. | | W. F. Jankowski | | 2007 Eastern Ave. Balto. Md. 21231 | |



THE BODY OF HENRY HAYNES WAS RELEASED TO THE JOHNS HOPKINS HOSPITAL
ON APPROVAL BY DR. PETTY MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|--|--|
| BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) | | BIRTH NO. 65 13244 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13244 | |
| HENRY ALAN HAYNES | | 2. DATE AND HOUR OF DEATH 12-23-65 | | 4:35 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND, WASHINGTON C. CITY OR TOWN (If outside city limits, write RURAL and give township) BOONESBORO D. STREET ADDRESS (If rural, give location) 105 N. MAIN ST. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8-11-03 | 9. AGE (In years last birthday) 62 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager | | 10B. KIND OF BUSINESS OR INDUSTRY Rubber Industry | | 11. BIRTHPLACE (State or foreign country) Rohrererville, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME DAVID HAYNES | | 14. MOTHER'S MAIDEN NAME CLARA POFFENBERGER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 705-10-8684 | | 17. INFORMANT Mrs. Louise M. Haynes Boonsboro, Md. | |
| 18. 4-21-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Congestive Heart Failure (B) Rupture of Aortic Valve (C) Bacterial Endocarditis 100% Body Burn as a consequence of instrumentation used during resuscitation | | INTERVAL BETWEEN ONSET AND DEATH 7mo 7mo 7mo 7wks | |
| 19A. DATE OF OPERATION 11-3-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC REGURGITATION | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Johns Hopkins Hospital | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 11/3/65 AND pm | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Burned during resuscitation with heating mattress. | |
| 22. I certify that (I) (this hospital) attended the deceased from OCTOBER 21, 1965 to DECEMBER 23, 1965, that (I) (we) last saw the deceased alive on DECEMBER 23, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. O'Neal Humphries M.D. | | | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) J. O'NEAL HUMPHRIES | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-26-65 | | 24C. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | |
| 24D. LOCATION Boonsboro, Md. | | 24E. NAME OF REGISTRAR DEC 28 1965 | | 24F. FUNERAL DIRECTOR John H. Bast, Jr. Boonsboro, Maryland | |

THE CHURCH OF THE FUTURE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|---|---|--|--|-----------------------------------|--|
| BIRTH NO. 65 13245 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 13245 | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary Smith</i> | | | | | 2. DATE AND HOUR OF DEATH <i>Dec 24-1965 10 PM</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i> | | (If not in hospital or institution, give street address or location) | | | A. STATE <i>Balt - md</i> | | B. COUNTY <i>13-01</i> | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>2325 Calver Ave</i> | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) | | 8. DATE OF BIRTH <i>9-8-1912</i> | 9. AGE (In years last birthday) <i>53</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | |
| 13. FATHER'S NAME <i>Not Known</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Dorothy Harding</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>Not Known</i> | | 17. INFORMANT <i>Marshall Peltard</i> | | ADDRESS <i>2325 Calver Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO <i>Adeno Carcinoma</i> <i>Left inguinal and</i> (B) DUE TO <i>Sub inguinal Region</i> (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-23-65</i> to <i>12-24-65</i> , that (I) (we) last saw the deceased alive on <i>12/22/65</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>James Johnson</i> M.D. | | | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>James Johnson</i> M.D. | | | | | | 23D. ADDRESS <i>403 Medical Bldg</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-28-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem</i> | | 24D. LOCATION (City, town, or county) (State) <i>Anne Arundel Co. md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Smith</i> | | 25C. FUNERAL DIRECTOR <i>George J. K...</i> | | ADDRESS <i>1348 Calver St</i> | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. E-120 65 13246 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13246 | |
|--|------------------|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) William A. Epps | | | | 2. DATE AND HOUR OF DEATH December 25, 1965 10:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 19-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1327 Lemmon Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 9-30-1898 | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer ret. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Andrew Epps | | | | 14. MOTHER'S MAIDEN NAME Louise ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., #21224 | | | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO CVA's, multiple (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 5 year | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) this hospital attended the deceased from 10-11-65 1965 to 12-25 1965, that (2) we lost saw the deceased alive on 12-25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Brian Bouton | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) BRIAN BOUTON | | | | 23D. ADDRESS M.D. 4940 Eastern Ave., Baltimore, Md., #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 30/65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR William [Signature] | | ADDRESS 3188 Schradu St | |

CV A: multiple

15-52
CL

10-11-52
CL

15-52
CL



Green (white)

BE/IN BOUTON

EXH

X

15-52 CL

BALTIMORE CITY HEALTH DEPARTMENT

65 13247 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13247

BIRTH NO. 65 13247

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JAMES JACKSON Jr.

2. DATE AND HOUR PRONOUNCED DEAD 25 December 1965 2:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 2206 W. Fayette St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

5. SEX male

6. RACE negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married Sep.

8. DATE OF BIRTH Oct. 5, 1936

9. AGE (In years last birthday) 29

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck helper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Winnsboro S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Jackson Sr.

14. MOTHER'S MAIDEN NAME Maggie Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 248-52-9415

17. INFORMANT ADDRESS Lottie Henderson 2206 W. Fayette St.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

(A) Stab wound of chest DUE TO

(B) DUE TO

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Cr. Fayette and Smallwood Sts.

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute) Dec. 25, 1965 2:20 p.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? stabbed in chest

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty

EXAMINER'S NAME (Type) Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 12/26/65

23A. BURIAL CREMATION, REMOVAL (Specify) Shipped

23B. DATE Dec. 29, 1965

23C. NAME OF CEMETERY or CREMATORY Winnsboro S.C.

23D. LOCATION (City, town, or county) (State) Winnsboro S.C.

24A. DATE REC'D BY HEALTH DEPT. DEC 28 1965

24B. NAME OF REGISTRAR Robert E. Jenkins

24C. FUNERAL DIRECTOR Williams Funeral Home

24D. ADDRESS 319 N. Schroeder St.

WALLACE POLICE

RECORDS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13248 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13248 | |
|--|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Evelyn Brogden | | Dec. 23, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Md. B. COUNTY | | | |
| 123 N. Carlton St. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 123 N. Carlton St. | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Female | | Col. | | Single | | Aug. 25, 1929 | |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 36 | | Factory Worker | | Balto. Md. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William Brogden | | | | Ella Simms | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | | | Ella Brogden 123 N. Carlton St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) DUE TO | | (B) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 13/65 to Dec. 3 1965, that (I) (we) last saw the deceased alive on Dec. 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Charles Tommasello M.D. | | | | 12/27/1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Charles Tommasello | | | | 910 W. Lombard St. Balt. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | Dec. 28, 1965 | | Mt. Auburn Cem. | | Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 28 1965 | | Robert E. Johnson | | William T. Ford | | 317 N. Howard St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------------|---|--|--|--|--|----------------------------------|--|--|
| BIRTH NO. 65 13249 | | | | | CERTIFICATE OF DEATH | | Registered No. 65 13249 | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED (Type or Print) <i>Ernest Cook</i> | | | | |
| 2. DATE AND HOUR OF DEATH <i>12-25-65</i> | | | | | M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lincoln Nursing Home</i> | | | | | A. STATE <i>Md.</i> B. COUNTY <i>18-02</i> | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i> | | | | | D. STREET ADDRESS (If rural, give location) <i>27 M Carey St.</i> | | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>May 12, 1876</i> | 9. AGE (in years last birthday) <i>89</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Laborer</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <i>Tessup Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Robert Cook</i> | | | 14. MOTHER'S MAIDEN NAME <i>Laura Oden</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. <i>220-015030</i> | | | 17. INFORMANT <i>Carrie Cook</i> | | | ADDRESS <i>812 W. Livingston St.</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH (A) DUE TO <i>Arteriosclerosis</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>7</i> | | | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | (B) DUE TO <i>Hypertension</i> | | | (C) <i>Here 1/2 yrs</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>6/10/1960</i> to <i>12/23/1965</i> , that (I) (we) last saw the deceased alive on <i>12/23/1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/25/65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i> | | | | | 23D. ADDRESS <i>403 M. D. [Signature]</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Dec. 1965</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR <i>[Signature]</i> | | ADDRESS <i>319 N. [Signature]</i> | | | |

THE UNIVERSITY OF CHICAGO

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LIBRARY

The body of George Walton was released to The Johns Hopkins Hospital NON_MED

Examiners Office 12-26-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|---|--|---|
| BIRTH NO. 65 13250 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13250 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) George Walton | | | 2. DATE AND HOUR OF DEATH 12-26-65 10:40 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1325 North Eden Street | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-10-95 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steel Worker | | | 11. BIRTHPLACE (State or foreign country) Mecherim Va. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Mack Walton | | | 14. MOTHER'S MAIDEN NAME Lizzie Booker | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 217-01-4066 | | 17. INFORMANT Helen Rebecca Chapman Walton |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Benign Prostatic Hypertrophy | | | CAUSE OF DEATH (A) DUE TO Adenocarcinoma of the Stomach (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 yr |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-26-65 19 to 12-26-65 19, that (I) (we) last saw the deceased alive on 12-26-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. L. Spivak M.D. signed for L. Silver | | | | 23B. DATE SIGNED 12/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) J. L. SPIVAK M.D. for L. Silver | | | | 23D. ADDRESS J. H. H. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 30/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemo. | |
| 24D. LOCATION (City, town, or county) (State) A.A. County Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. [unclear] | | 25C. FUNERAL DIRECTOR Milton E. Ellicker 11297 [unclear] | | | |

Mr. J. H. H. H.

Mr. J. H. H. H.

Mr. J. H. H. H.

Mr. J. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------------|--|-------------------------------------|---|--|
| BIRTH NO. 65 13251 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13251 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Henry Ellington Jones</i> | | 2. DATE AND HOUR OF DEATH <i>December 26 1965 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <i>md.</i> B. COUNTY <i>8-05</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| | | D. STREET ADDRESS (If rural, give location) <i>1712 Normal Ave</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>11/12/09</i> | 9. AGE (In years last birthday) <i>56</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steelworker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i> | |
| 13. FATHER'S NAME <i>?</i> | | 14. MOTHER'S MAIDEN NAME <i>?</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>30-179-16-10</i> | | 17. INFORMANT <i>Suey M. Jones Phipps</i> | |
| 18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease or injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Hypertensive arteriosclerotic C.V.D.</i> | | 19. CAUSE OF DEATH <i>Hypertensive arteriosclerotic C.V.D.</i> | | ADDRESS <i>1712 Normal Ave</i> INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-11-1965</i> to <i>12-24-1965</i> , that (I) (we) last saw the deceased alive on <i>12-24-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>C.R. Campbell</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12-27-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>C.R. Campbell</i> | | 23D. ADDRESS <i>1618 W. North Ave., Baltimore, Md.</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | | 24B. DATE <i>Dec 30/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Tracy Mount N.C.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Tracy Mount N.C.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>P.L. & B. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Frank E. Hickman</i> | | | |
| 25D. ADDRESS <i>1129 N. Carolina St</i> | | | | | |

Miss Clara
Lester
1874



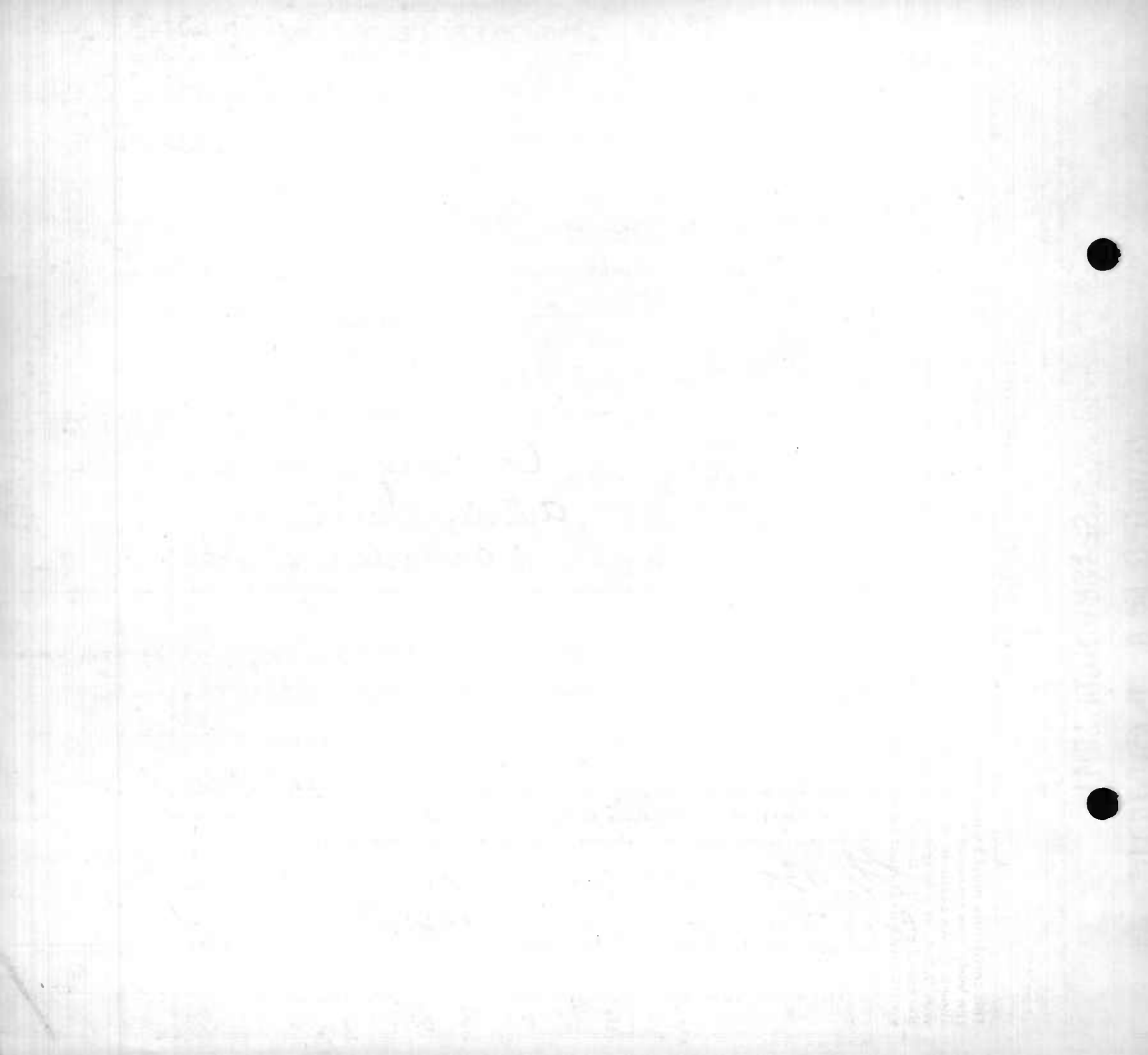
My Mother
1874

1874

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|-----------|--|------------------|--|----------------------------|
| 65 13252 | | 65 13252 | | 65 13252 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | Ester Simpkins | | December 20, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | B. COUNTY | | Md. | |
| Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | E. STREET ADDRESS | | 1724 N. Wolfe St | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| Female | Colored | Widowed | Jan 18, 1875 | 90 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Domestic | | | | Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Isaac Beckett | | Ester Sterenson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Katherine Jackson 1724 N. Wolfe St | |
| 18. 4 20 1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Coronary Occlusion Sudden | |
| ANTECEDENT CAUSES | | (B) DUE TO | | arterio Sclerotic Cordis | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Vascular disease 10 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1 1965 to Dec 20 1965, that (I) (we) last saw the deceased alive on Dec 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| G.M. Baumgardner M.D. | | 12/21/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| G.M. Baumgardner M.D. | | Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | Dec 24/65 | Mt Calvary Cemetery | | A.A. County Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 28 1965 | | J. E. Eichen | | 1129 N. Caroline St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. 65 13253 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13253 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Monzella Pryor</i> | | 2. DATE AND HOUR OF DEATH <i>12-26-65 1:30 PM</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lincoln Nursery Home 27 N Carey St Baltimore</i> | | A. STATE <i>Dea. Hants Dea. Hants</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Md.</i> | |
| 5. SEX <i>Male</i> | | 6. RACE <i>negro</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i> | |
| 8. DATE OF BIRTH <i>Nov 6, 1903</i> | | 9. AGE (In years last birthday) <i>62</i> | | 10. Under 1 Yr. Months Days If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Henry Johnson</i> | | 14. MOTHER'S MAIDEN NAME <i>Chatty 3 Mary Smith</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <i>352X1</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO <i>Left Hemiplegia</i> | | <i>few</i> | |
| ANTECEDENT CAUSES | | (B) DUE TO | | <i>years</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-64</i> to <i>12-26-65</i> 19 <i>65</i> that (I) (we) last saw the deceased alive on <i>12-26</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>MD Johnson</i> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>MD Johnson</i> | | | | 23D. ADDRESS <i>403 Med Arts Bldg</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| <i>Burial</i> | | <i>12/29/65</i> | | <i>Int. Calvary Cem</i> | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR | | 24F. ADDRESS | |
| <i>99. County</i> | | <i>Milton E. Edickson</i> | | <i>1129 N. Carlton St.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | | | | |

21 N. 1st St.
New York, N.Y.

October 10, 1903

Dear Sir,

Very respectfully,
Yours truly,
J. M. Smith

Harvey Johnson
Manager

100 N. 1st St.
New York, N.Y.
October 10, 1903
J. M. Smith

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|-----------------------------|---|--|
| BIRTH NO. 65 13254 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13254 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) John H. Clopsin | | 2. DATE AND HOUR OF DEATH Dec. 27, 1965 10:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 25-31 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Md. Gen'l Hosp | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 29 | | | |
| | | D. STREET ADDRESS (If rural, give location) 5170 Stafford Rd | | | |
| 5. SEX Male | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/5/84 | 9. AGE (In years, last birthday) 78 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cumberbund B. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. U.S.A. | |
| 13. FATHER'S NAME Peter Clopsin | | 14. MOTHER'S MAIDEN NAME Annie Smick | | 12. CITIZEN OF WHAT COUNTRY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-18-1547 | | 17. INFORMANT ADDRESS | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Coronary Occlusion DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 4 hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Arteriosclerotic cardiovascular disease 10 yrs DUE TO | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION *** | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ***** | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If by medical examiner) *** | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ***** | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ***** | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) ***** | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? ***** | |
| 22. I certify that (I) did not attended the deceased from 19 50 to December 19 65, that (I) did not saw the deceased alive on December 24, 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not (did) view the body after death. | | | | | |
| 23A. SIGNATURE Millard T. Traband, Jr. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 28 Dec. 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. | | 23D. ADDRESS 5101 Gwynn Oak Ave. Baltimore, Md. 21207 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 12/30/65 | | 24B. DATE 12/30/65 | | 24C. NAME OF CEMETERY or CREMATORY Landon Park Burial | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Terhune, M.D. | |
| 25C. FUNERAL DIRECTOR Witke, F. W. 4101 Calverton | | 25D. ADDRESS | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|--|--|--|--|------------------------------|--|--|
| BIRTH NO. 65 13255 | | CERTIFICATE OF DEATH | | | | Registered No. 65 13255 | | | |
| 1. NAME OF DECEASED (Type or Print) Emma V. Milligan | | | | | 2. DATE AND HOUR OF DEATH December 26, 1965 10:15 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 500 N. Robinson Street | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY H-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 500 N. Robinson Street | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 10/13/1902 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady | | 10B. KIND OF BUSINESS OR INDUSTRY McCrony 5¢ & 10¢ | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Joseph Diggs | | | | | 14. MOTHER'S MAIDEN NAME Emma V. Hartley | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-05-9189 | | 17. INFORMANT ADDRESS Stanley Milligan 7409 Holabird Ave. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) carcinoma of pancreas DUE TO (B) biliary obstruction and jaundice DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 5 months 6 months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1965 to Dec 26 1965, that (I) (we) last saw the deceased alive on Dec 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Burton V. Lock M.D. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/27/65 | | |
| 23C. PHYSICIAN'S NAME (Type) BURTON V. LOCK | | | | | 23D. ADDRESS 2936 E. Balto St 212 24 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/29/1965 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR P.C. 1-2-3-4-5-6-7-8-9-10 | | 25C. FUNERAL DIRECTOR John A. Moran Inc. | | ADDRESS 3000 E. Baltimore St. | | | |

15/3/12
15/3/12

Boston V. Lock
Boston V. Lock

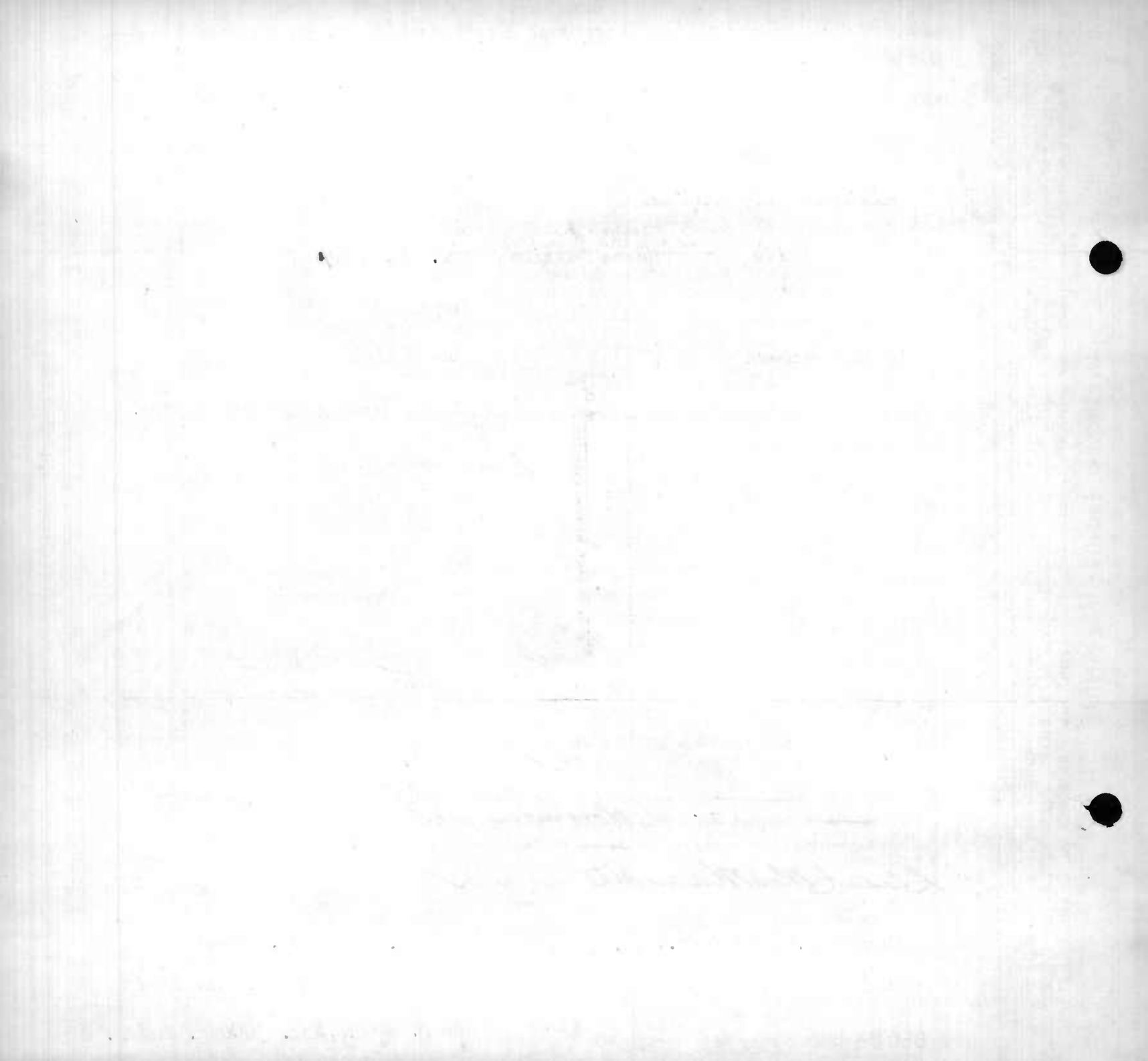
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

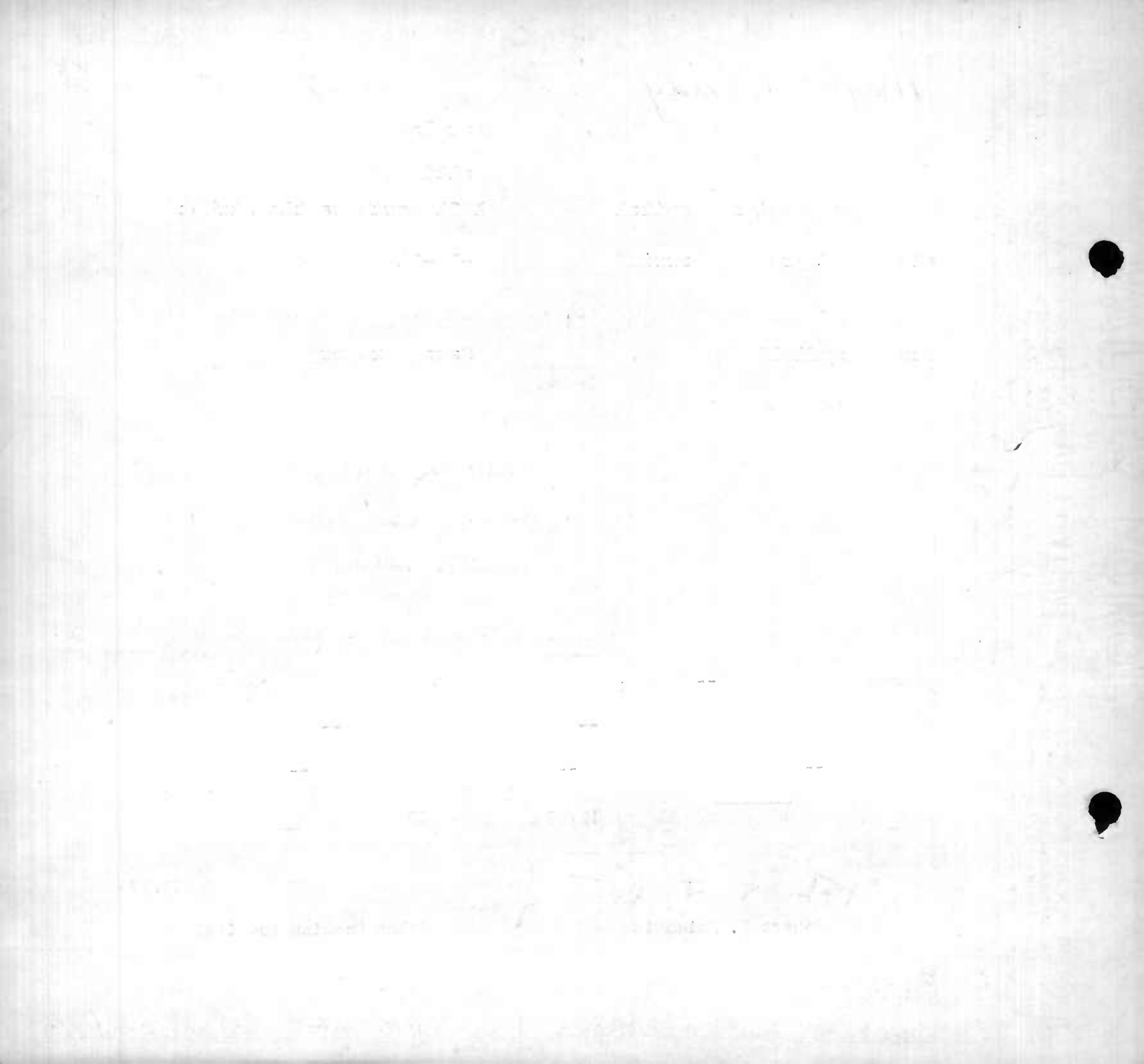
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|---|------------------------------|--|--|---|---|
| BIRTH NO. <u>64-041365</u> <u>13256</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65</u> <u>13256</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| <u>James Randolph Barbour</u> | | <u>December 27, 1965</u> | | <u>7:30 A. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u> | | | |
| <u>Baltimore City Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>921 Dalton Avenue</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>Feb. 23, 1964</u> | 9. AGE (In years last birthday) <u>1</u> | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>William Barbour</u> | | 14. MOTHER'S MAIDEN NAME <u>Ann Myrick</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>William Barbour 921 Dalton Ave.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) <u>491X I</u> | | CAUSE OF DEATH (A) <u>Pneumonia bronchial</u> (B) <u>2 days</u> (C) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 1965</u> to <u>Dec 26</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>November 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Charles C. MacMinn M.D.</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>Dec 27, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Charles C. MacMinn Jr., M.D.</u> | | 23D. ADDRESS <u>2900 E. Baltimore Street</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12/29/65</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1965</u> | | 25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>3000 E. Balto. St</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13257 | |
|---|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 65 13257 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED <i>Mayfield Goady</i> | | 2. DATE AND HOUR OF DEATH <i>12/27/65 1 6⁴⁵ P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i> | | A. STATE <i>Maryland</i> | | | |
| If not in hospital or institution, give street address or location | | B. COUNTY <i>8-05</i> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>1821 North Castle Street</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>8-28-21</i> | 9. AGE (In years last birthday) <i>44</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>JANITOR</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>SPARROWS POINT</i> | | 11. BIRTHPLACE (State or foreign country) <i>SOUTH CAROLINA</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Dotson Mayfield</i> | | 14. MOTHER'S MAIDEN NAME <i>Sarah Gregory</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES 12-18-42 to 12-27-45</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>WILLIE MAYFIELD 1737 E FEDERAL ST</i> | |
| 18. <i>260X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>ventricular arrhythmia</i> DUE TO | | <i>instantaneous</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>coronary artery atherosclerosis</i> DUE TO | | <i>years</i> | |
| | | (C) <i>Diabetes mellitus</i> | | <i>12 yrs</i> | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Pneumonia & septicemia - prob. pneumococcal 2 days</i> | |
| 19A. DATE OF OPERATION <i>none</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>--</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>--</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>--</i> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>--</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> -- Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>--</i> | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>12/26</i> 19 <i>65</i> to <i>12/27</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/27</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Robert I. Keimowitz</i> | | | | 23B. DATE SIGNED <i>12/27</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert I. Keimowitz</i> | | | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12-30-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE NATIONAL BALTIMORE MD</i> | |
| 24D. LOCATION <i>BALTIMORE MD</i> | | 24E. CITY, town, or county | | 24F. STATE | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | 25B. NAME OF REGISTRAR <i>JOSEPH KNIGHT</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>1639 N BRADWAY</i> | |



65 13258

BALTIMORE CITY HEALTH DEPARTMENT

65 13258

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT

BROOM

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1965

12:30 P.^{M.}

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

710 N. Gay Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SEPERATED

8. DATE OF BIRTH

12-1-1918

9. AGE (In years
last birthday)

44 47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

PAVING-CONTRACTOR

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALBERT BROOM

14. MOTHER'S MAIDEN NAME

ROSA MICKLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

11-20-43 TO 8-9-44

16. SOCIAL
SECURITY NO.

243-12-9701

17. INFORMANT

JOHN H. MICKLES

ADDRESS

1119 N. BRENTWOOD

18.

443X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hypertensive Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12-28-65

23C. NAME of CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

(City, town, or county)

BALTIMORE

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

24B. NAME OF REGISTRAR

Charles S. Petty, M.D.

24C. FUNERAL DIRECTOR

JOSEPH KNIGHT

ADDRESS

1639 N. BROADWAY

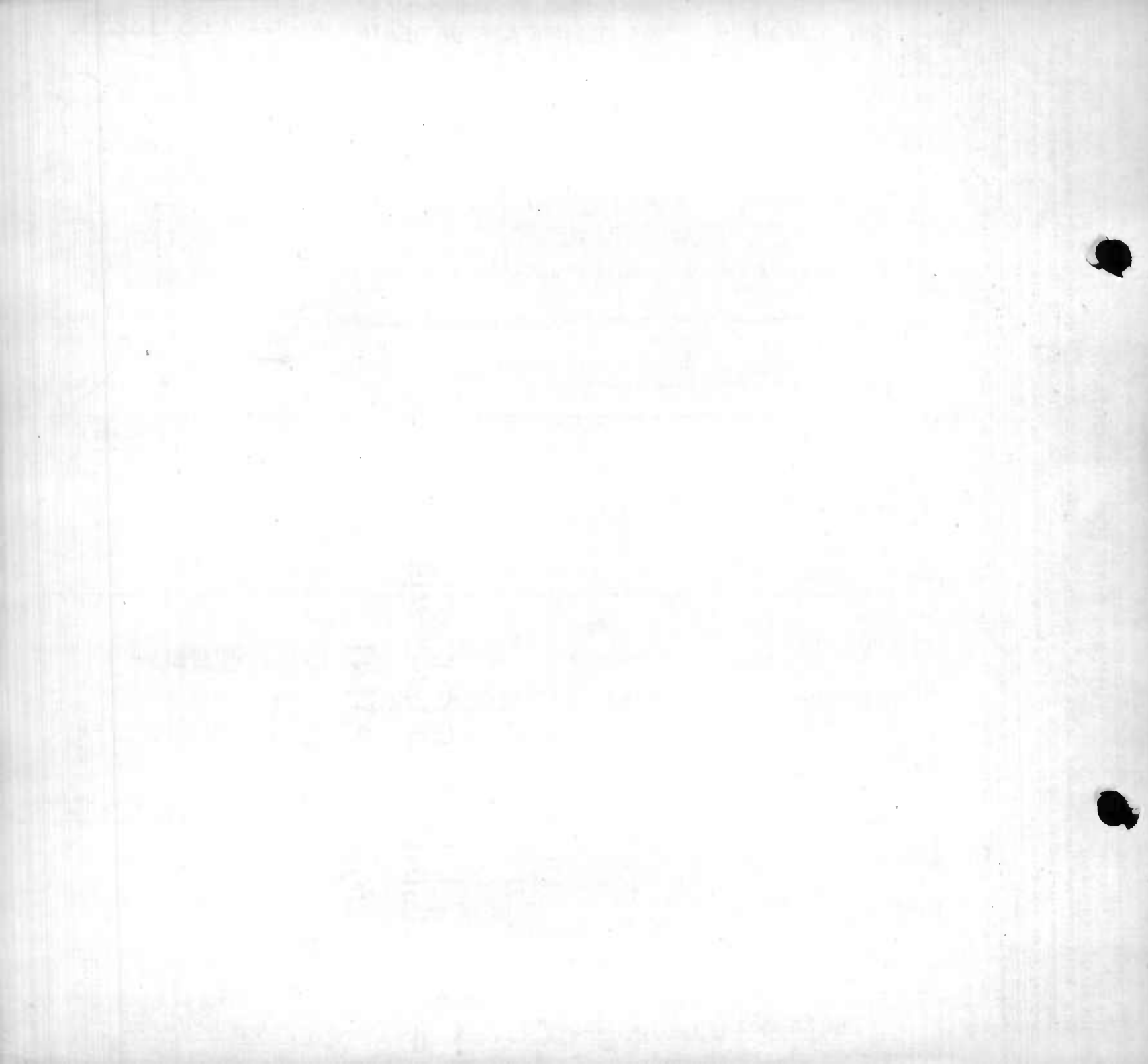
WATLEY FORD

ROAD COMMISSION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

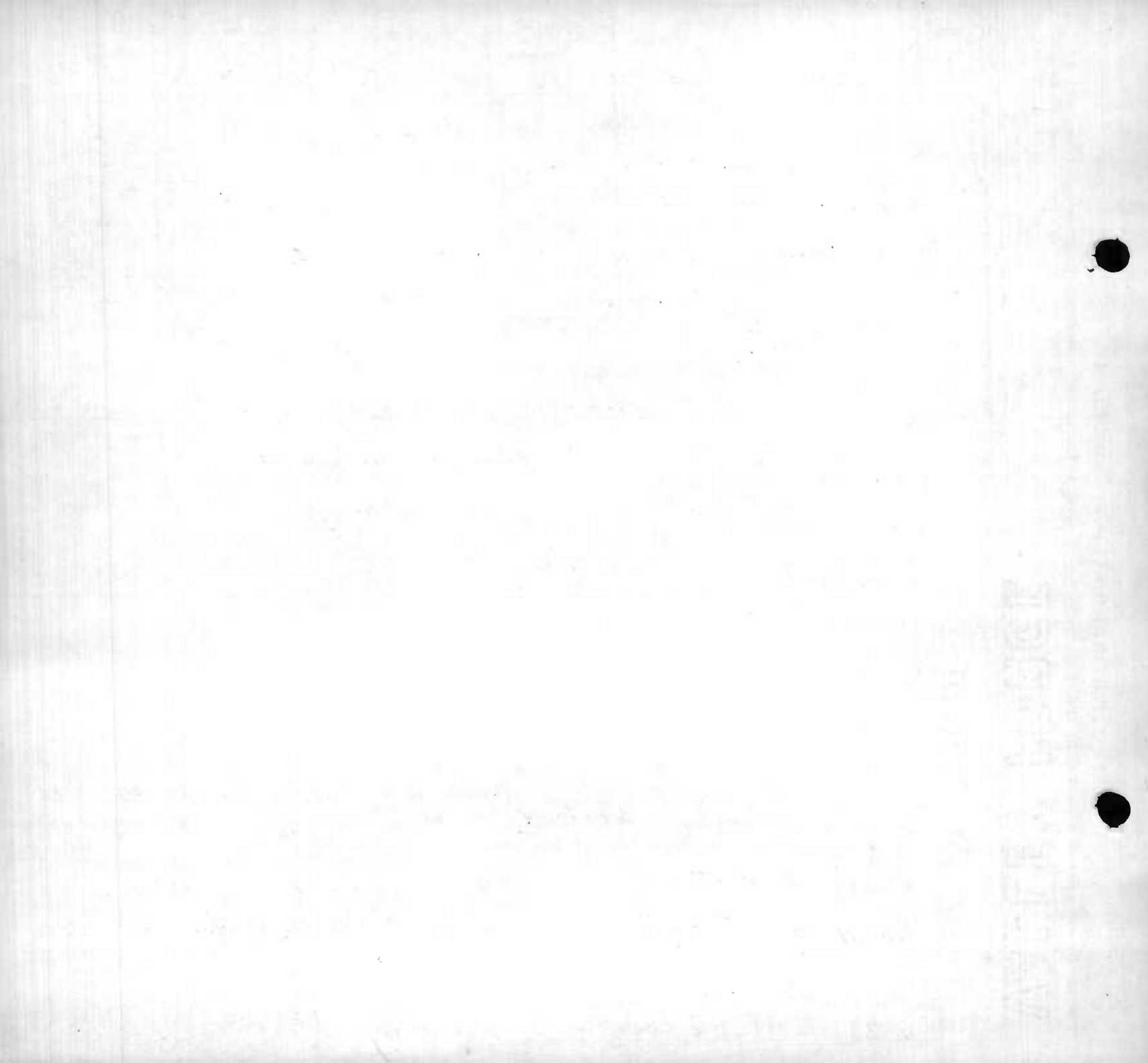
| BIRTH NO. 65 13259 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13259 | |
|---|---------------------|--|--|--|---|--|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Eliza Sims</i> | | | | 2. DATE AND/HOUR OF DEATH <i>12/26/65</i> <i>4:25 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>1321 W. Fayette St</i> | | B. COUNTY <i>19-02</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>1321 W. Fayette Street</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>N</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>Oct 8, 1923</i> | 9. AGE (In years lost birthday) <i>40</i> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress - up until April 1965</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Summerton, S.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Bernie Jones</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Jane Mae Jones nee Mark</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Husband</i> | | ADDRESS |
| 18. <i>171X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Shock due to Hemorrhage</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cancer of Cervix distant metastases</i> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/26</i> <i>1965</i> to <i>12/26</i> <i>1965</i> , that (I) (we) last saw the deceased alive on <i>12/26</i> <i>1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Rosevelt Taylor, Jr. M.D.</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/26/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Rosevelt Taylor, Jr. M.D.</i> | | | | 23D. ADDRESS <i>University Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <i>Burial</i> | | <i>12/31/65</i> | | <i>Springhill</i> | | <i>Summerton S.C.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Charles A. Rice</i> | | ADDRESS <i>661 W. Barre St</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|------------------------------|--|---|
| 65 13260 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13260 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH | |
| M.E. CASE NO. | | | | December 24, 1965 2 22 P M. | |
| 1. NAME OF DECEASED (Type or Print) | | ELAM, ANNIE M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. CITY Baltimore 16 | |
| Lutheran Hospital of Maryland Baltimore, Md. 21216 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| | | 1921 N. Longwood St. | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10/15/13 | 9. AGE (In years lost birthday) 52 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Home | | U. S. A. | |
| 13. FATHER'S NAME John G. Stokes | | 14. MOTHER'S MAIDEN NAME MARY Burns | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 24-14-1171 | | 17. INFORMANT Samuel Elam 1921 Longwood St. | |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH Advanced carcinoma of the breasts | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION Feb. 19/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Malignancy of breast | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 10 19 65 to December 24 19 65, that (I) (we) last saw the deceased alive on December 24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 2 32 PM | | | | | |
| 23A. SIGNATURE Manuel G. Fortanilla | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) Manuel G. Fortanilla | | 23D. ADDRESS Lutheran Hospital of Md. - Baltimore 16 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-28-65 | | 24C. NAME of CEMETERY or CREMATORY Carver Mem. Laurel Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR Morton & Gett 1701 Laurens | |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---|--|----------------------------------|--|---|--|----------------|--|
| 65 13261 | | | | | | 65 13261 | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| JOHN HENRY NICHOLSON | | | | 12/23/65 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE Maryland | | | |
| 20 N. Bruce St. | | | | B. COUNTY Baltimore | | | |
| 5. SEX male | | | | 6. RACE colored | | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH Feb-23-1897 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 9. AGE (In years last birthday) 68 | | | |
| Laborer | | | | 11. BIRTHPLACE (State or foreign country) BALTO. Md. | | | |
| 13. FATHER'S NAME Abraham Nicholson | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 14. MOTHER'S MAIDEN NAME Laura Hebron | | | |
| UNK. | | | | 16. SOCIAL SECURITY NO. 219-09-0032 | | | |
| 17. INFORMANT Mrs. Bessie Nicholson | | | | ADDRESS 20 N. Bruce St. | | | |
| 18. CAUSE OF DEATH 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| | | | | 20A. AUTOPSY? (Yes or No) no | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner H. Spitz, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 23B. DATE 12-28-65 | | | |
| 23C. NAME OF CEMETERY or CREMATORY MT. AUBURN | | | | 23D. LOCATION (City, town, or county) (State) BALTO., Md. | | | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | |
| 24C. FUNERAL DIRECTOR Morgan & Dyett | | | | ADDRESS 1701 Laurens St. | | | |

VALLEY FORD

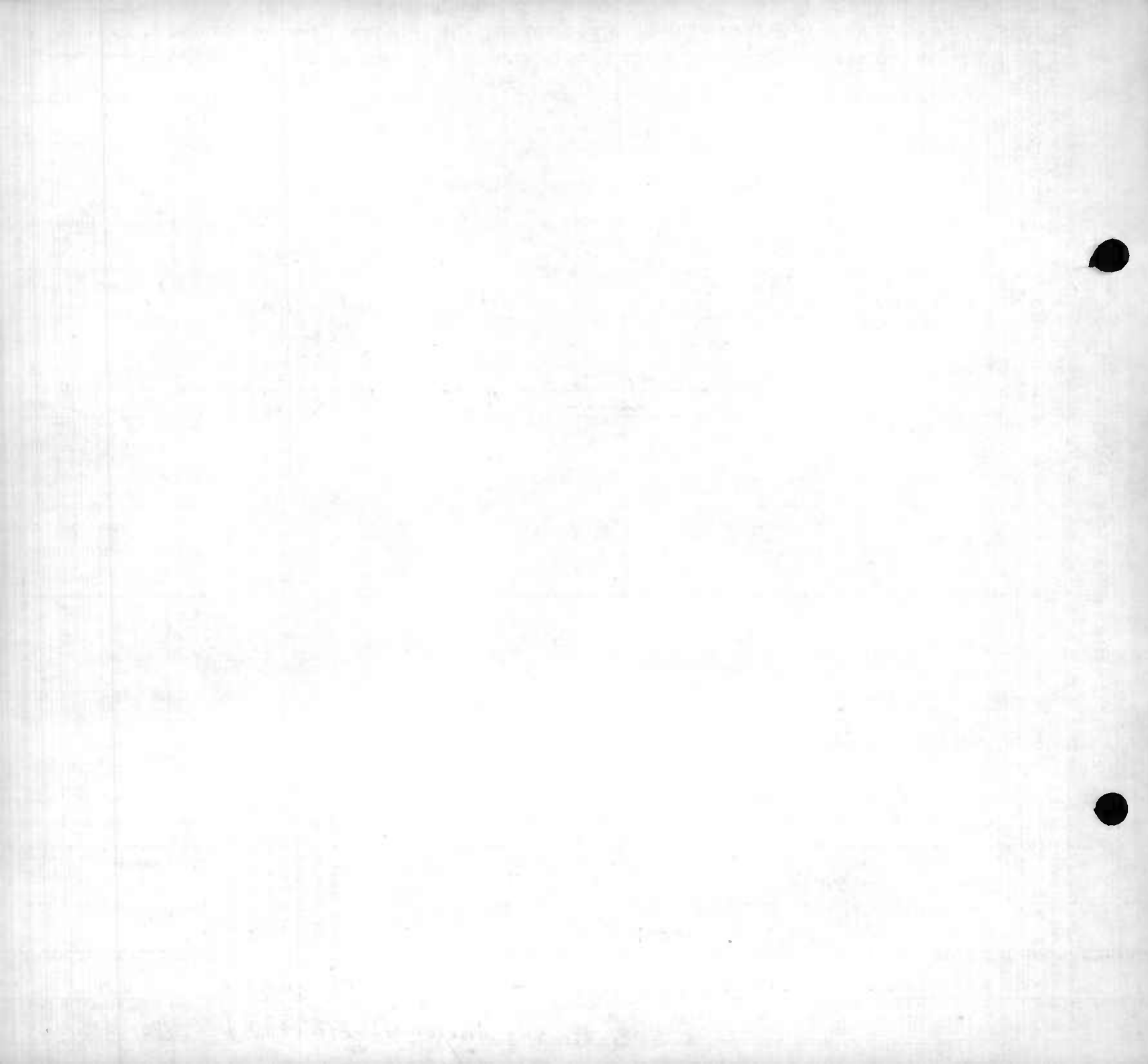
THIS DOCUMENT

1/1/71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13262 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13262 | |
|---|-----------------|--|--------------------------|---|-----------------------|--|----------------------|
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Robinson Josephine | | | | 2. DATE AND HOUR OF DEATH 12-24-65 1:20 p.m. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | | | A. STATE Maryland B. COUNTY 16-07 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1409 Duhamel Street | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widow | 8. DATE OF BIRTH 5-20-90 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 1 Hr. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Richmond VA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Morris | | | | 14. MOTHER'S MAIDEN NAME Mannie Giles | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 223-40-5012A | | 17. INFORMANT Mrs Sadie Lewis | | ADDRESS 660 E. 166th St. Bronx. | |
| 18. 199-2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) DUE TO Carcinomatosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | (B) DUE TO | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-3-1965 to 12-24-1965, that (I) (we) last saw the deceased alive on 12-24-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Nabil F. Warsol M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) Nabil F. Warsol M.D. | | | | 23D. ADDRESS University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-30-65 | | 24C. NAME OF CEMETERY or CREMATORY Evergreen Cem. | | 24D. LOCATION (City, town, or county) (State) Richmond VA. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert J. [unclear] | | 25C. FUNERAL DIRECTOR Morton H. Dyett | | ADDRESS Fun. H. 1701 LAURONS | |



BIRTH NO.

65 13263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

5 13263

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT

TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1965

11:20 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1316 Bruce Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1316 Bruce Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widow

8. DATE OF BIRTH

Sept 25-1915

9. AGE (In years
last birthday)

50

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State foreign country)

Pitts Co. Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Taylor

14. MOTHER'S MAIDEN NAME

Aria Gatewood

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

229-12-1789

17. INFORMANT

Nannie B Towler

ADDRESS

612 N. Pulaski St

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Emphysema.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID ☐ IN BALTIMORE CITY, GIVE EXACT LOCATION
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐
m. WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/21/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-27-65

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

24B. NAME OF REGISTRAR

P. L. A. E. J. J. J.

24C. FUNERAL DIRECTOR

The Mortons & Dyett

ADDRESS

1701 Laurens St

VALLEY PARK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|-----------------------------------|--|---|--|--|--|--|
| BIRTH NO. 65 13264 | | | | | CERTIFICATE OF DEATH | | Registered No. 65 13264 | | |
| 1. NAME OF DECEASED (Type or Print) <i>Martha Pierce</i> | | | | | 2. DATE AND HOUR OF DEATH <i>12-25 6:30 P.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>18-02</i> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>27 N. Carey</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO.</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>27 N. Carey ST.</i> | | | | |
| 5. SEX <i>Fe.</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Wid.</i> | 8. DATE OF BIRTH <i>8-1911</i> | 9. AGE (In years last birthday) <i>54</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>N.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 13. FATHER'S NAME <i>George STaley</i> | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>M. Johnson</i> | | ADDRESS <i>2933 Walbrook Ave</i> | | |
| 18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) DUE TO <i>Cardio Vascular Disease</i> (B) DUE TO <i>arterial Hypertension</i> (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-17-65</i> to <i>12-25-65</i> , that (I) (we) last saw the deceased alive on <i>12-25-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> M.D. | | | | | 23B. DATE SIGNED | | | 23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i> | |
| | | | | | 23D. ADDRESS <i>403 Med Arts Bldg</i> M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-30-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Carver Mem.</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Laurel Md</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | 25B. NAME OF REGISTRAR <i>[Signature]</i> | | | 25C. FUNERAL DIRECTOR <i>MORTON, Pyett</i> ADDRESS <i>1701 Laurens ST</i> | | | | |

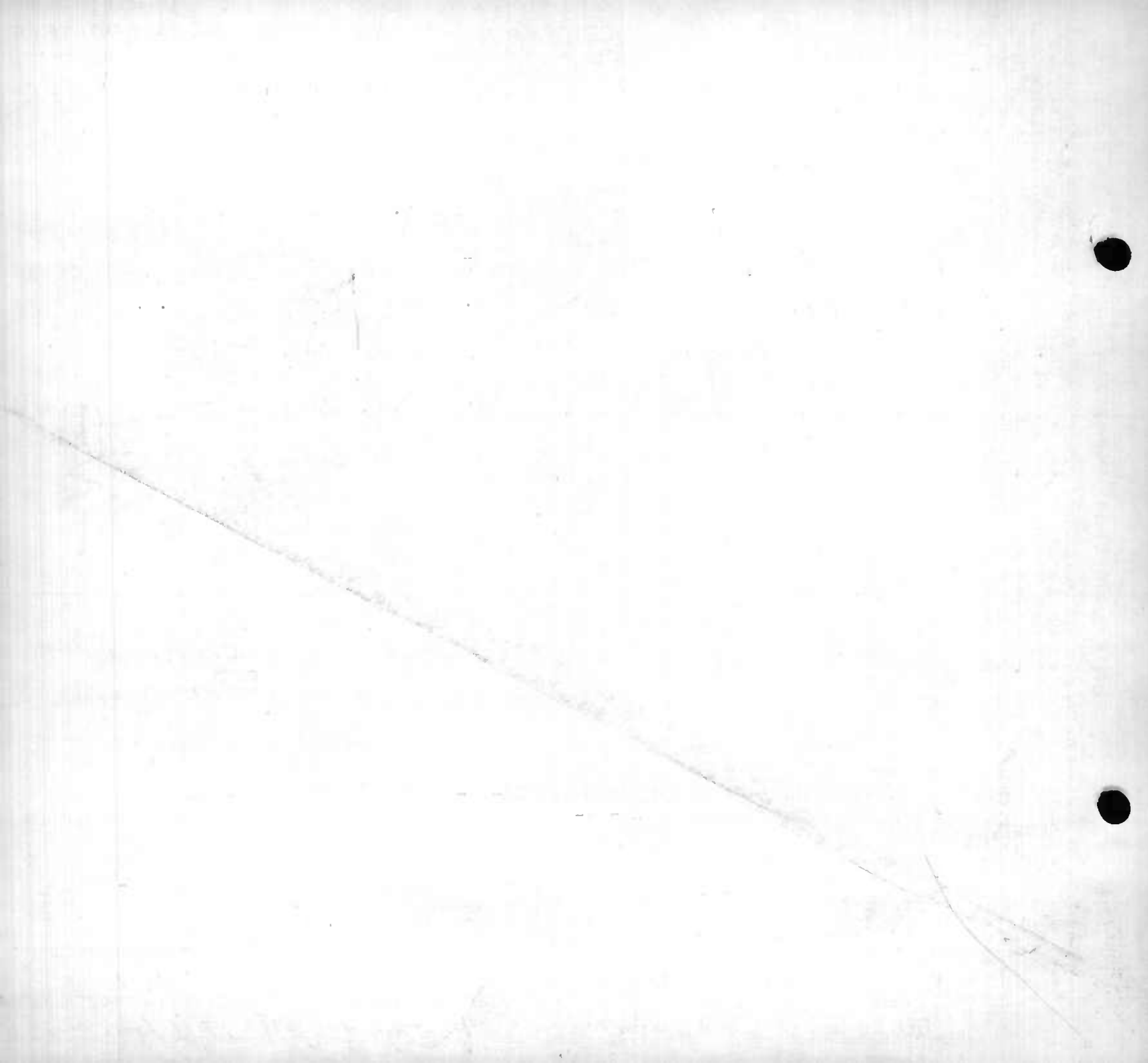
WALTER H. FORGIE

WALTER H. FORGIE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|--|--|---|--|
| BIRTH NO. 65 13266 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13266 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Mattie Christian | | | 2. DATE AND HOUR OF DEATH December 24, 1965 7 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland | | | A. STATE Maryland B. COUNTY 17-02 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 543 W. Lanvale Street | | |
| 5. SEX femal | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 3-1861 | 9. AGE (In years last birthday) 104 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) N. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME MACK | | | 14. MOTHER'S MAIDEN NAME MARIA MACK | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Willette Barber |
| | | | ADDRESS 438 Cleveland St. | | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Hyfertentive Heart Disease DUE TO (B) A S H D DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-23-65 to 12-24-1965 , that (I) (we) last saw the deceased alive on 12-24-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Theodore | | | | 23B. DATE SIGNED 12-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) Roger Theodore | | | | 23D. ADDRESS 1514 Division Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-24-65 | | 24C. NAME of CEMETERY or CREMATORY MT. Auburn | |
| 24D. LOCATION BALTO, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | |
| 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR MORTON & DYETT | | | |
| ADDRESS 1701 Laurens | | | | | |



1
R-152

65 13267

BALTIMORE CITY HEALTH DEPARTMENT

65 13267

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | |
|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) VIOLA ROBINSON | | 2. DATE AND HOUR PRONOUNCED DEAD 24 December 1965 6:50 p. <small>M.</small> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1714 N. Carey St. | |
| 5. SEX female | 6. RACE negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) sep. | 8. DATE OF BIRTH 12-24-04 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY 1 | 9. AGE (In years last birthday) 61 |
| 13. FATHER'S NAME Noah Johnson | | 12. CITIZEN OF WHAT COUNTRY? 15-01 | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-16-3296 | 14. MOTHER'S MAIDEN NAME Cassie Johnson |
| 17. INFORMANT Mrs. Myrtle Sye | | ADDRESS 107 N. Carrollton Ave. | |
| 18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) no | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12-24-65 | 23C. NAME of CEMETERY or CREMATORY MT. Auburn |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 24B. NAME OF REGISTRAR John E. Fink | 24C. FUNERAL DIRECTOR Morton + Dyett |
| | | ADDRESS 1701 Laurens St. | |

WALLIE V. FORGE

RAILROAD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13268 | |
|---|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. 65 13268 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Jackson, Willie MI | | 2. DATE AND HOUR OF DEATH 12/26/65 7:50P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 17-01 | | | |
| FULL NAME OF (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 571 W. Biddle St. | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2/12/94 | 9. AGE (In years lost birthday) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Ridgeby, South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George, Jackson | | 14. MOTHER'S MAIDEN NAME Sue Dorsey | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/22/18-6/5/19 | | 16. SOCIAL SECURITY NO. 215-09-7794 | | 17. INFORMANT ADDRESS Veterans Hospital Records, Balto., Md. | |
| 18. 527.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Emphysema, Obstructive | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 10 Yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arterioscleriotic Heart Disease | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Dec. 19, 1965 to December 26, 1965 , that (2) (we) last saw the deceased alive on December 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Young E. Chun | | 23D. ADDRESS M.D. Veterans Administration Hospital, Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-30-65 | | 24C. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL | |
| 24D. LOCATION BALTO. Md. | | 24E. NAME OF REGISTRAR Robert E. Johnson | | 24F. FUNERAL DIRECTOR MORTON & DOTT | |
| 24G. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 24H. NAME OF REGISTRAR Robert E. Johnson | | 24I. ADDRESS 1701 LAURENS ST. | |

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| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13269 | |
|---|---------|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| CHARLES THOMAS | | | December 20, 1965 6:00 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | A. STATE Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | B. COUNTY | | |
| 37 Mercy Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 706 N. Mount Street | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Male | Negro | Divorced | July-31-1907 | 58 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| PORTER | | | Washington Ark. | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Ben Thomas | | | Mollie Duffin | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | 408-12-0094 | Mrs. Laura Gordon 706 N. Mount St | | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| (A) Massive Subarachnoid Hemorrhage | | | | | |
| (B) Rupture of Congenital Aneurysm. | | | | | |
| (C) | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| Hypertensive and Arteriosclerotic Cardiovascular Disease | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | | Yes | Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | Charles S. Petty, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | 23C. NAME of CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) | (State) |
| Burial | | 12-24-65 | MT. Auburn | Ba Ho, | Md. |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| DEC 28 1965 | | Robert E. Fisher, M.D. | | Morton J. Dye 1701 Laurens | |

WALLEY FORGE

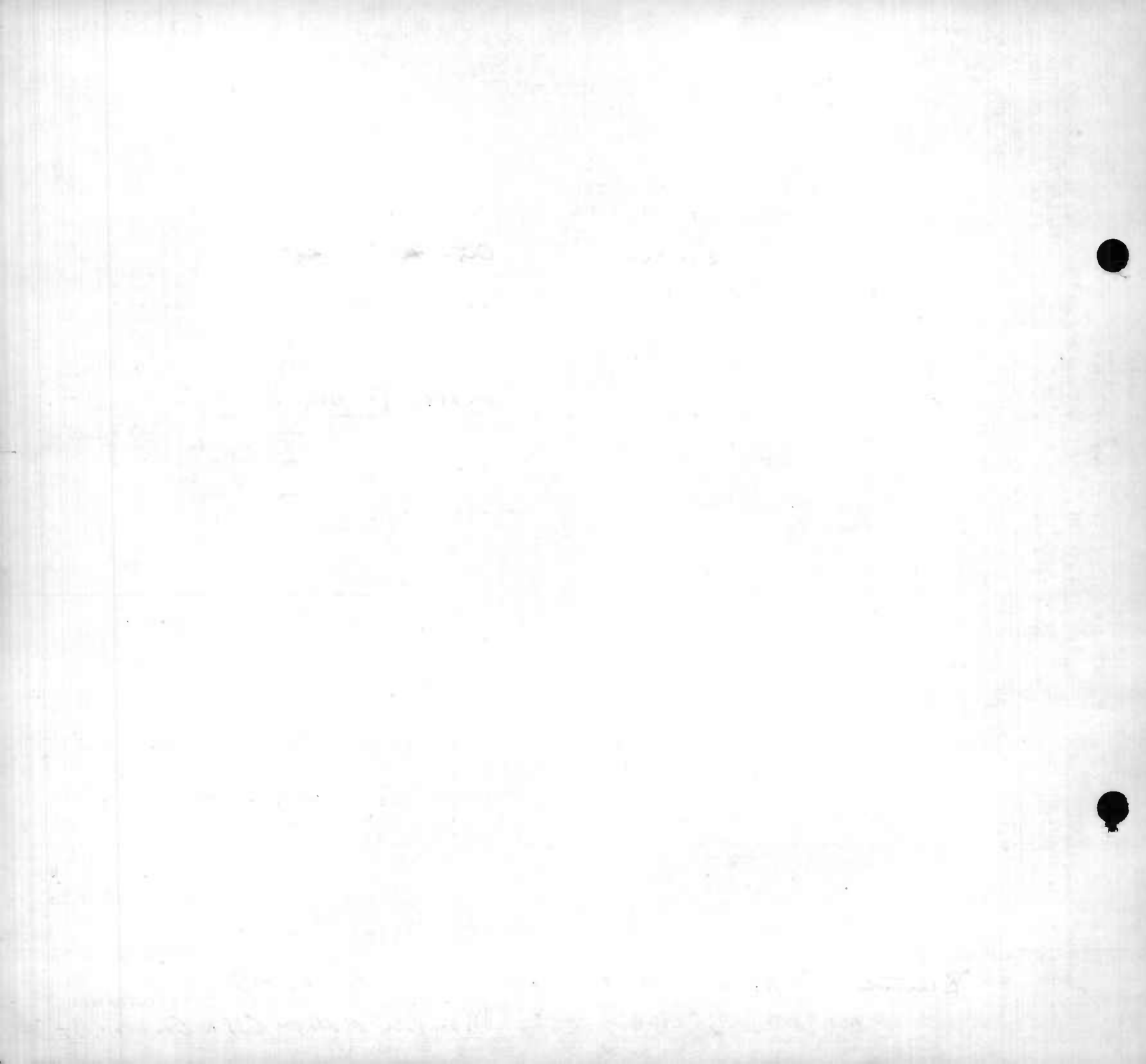
WALLEY FORGE

General Order of the
Honorable John J. Waller
Major

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|------------------------------|--|--|
| BIRTH NO. 65 13270 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13270 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Eula Reddick (Eulee Reddick) | | 2. DATE AND HOUR OF DEATH December 24, 1965 10:55 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland | | A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1135 N. Gilmore Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH OCT-1908 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N. Carolina | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME James Reddick | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MYRTLE REDDICK 1135 N Gilmore St | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) C.V.A. DUE TO A.S.C.V.D. (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Congestive Heart Failure | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 23, 1965 to December 24, 1965, that (I) (we) last saw the deceased alive on December 24, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED December 24, 65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Andre Rigaud | | 23D. ADDRESS M.D. 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/29/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn | |
| 24D. LOCATION Baltimore | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR Maurice P. Hayes 638 N Gilmore St | |



H 200

65 13271

BALTIMORE CITY HEALTH DEPARTMENT

65 13271

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ELLA A HAYES

2. DATE AND HOUR PRONOUNCED DEAD

25 December 1965 10:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1017 N. Mount St.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

MAY 6 - 1929

9. AGE (In years last birthday)

36

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

DOMESTIC

10B. KIND OF BUSINESS OR INDUSTRY

Put Family

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GREEN JOHNSON

14. MOTHER'S MAIDEN NAME

HELEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

216-24-5371

17. INFORMANT

ADDRESS

William Hayes, 1017 N. Mount St

18. 163A I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/26/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12/26/65

23C. NAME of CEMETERY or CREMATORY

mt Auburn

23D. LOCATION (City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

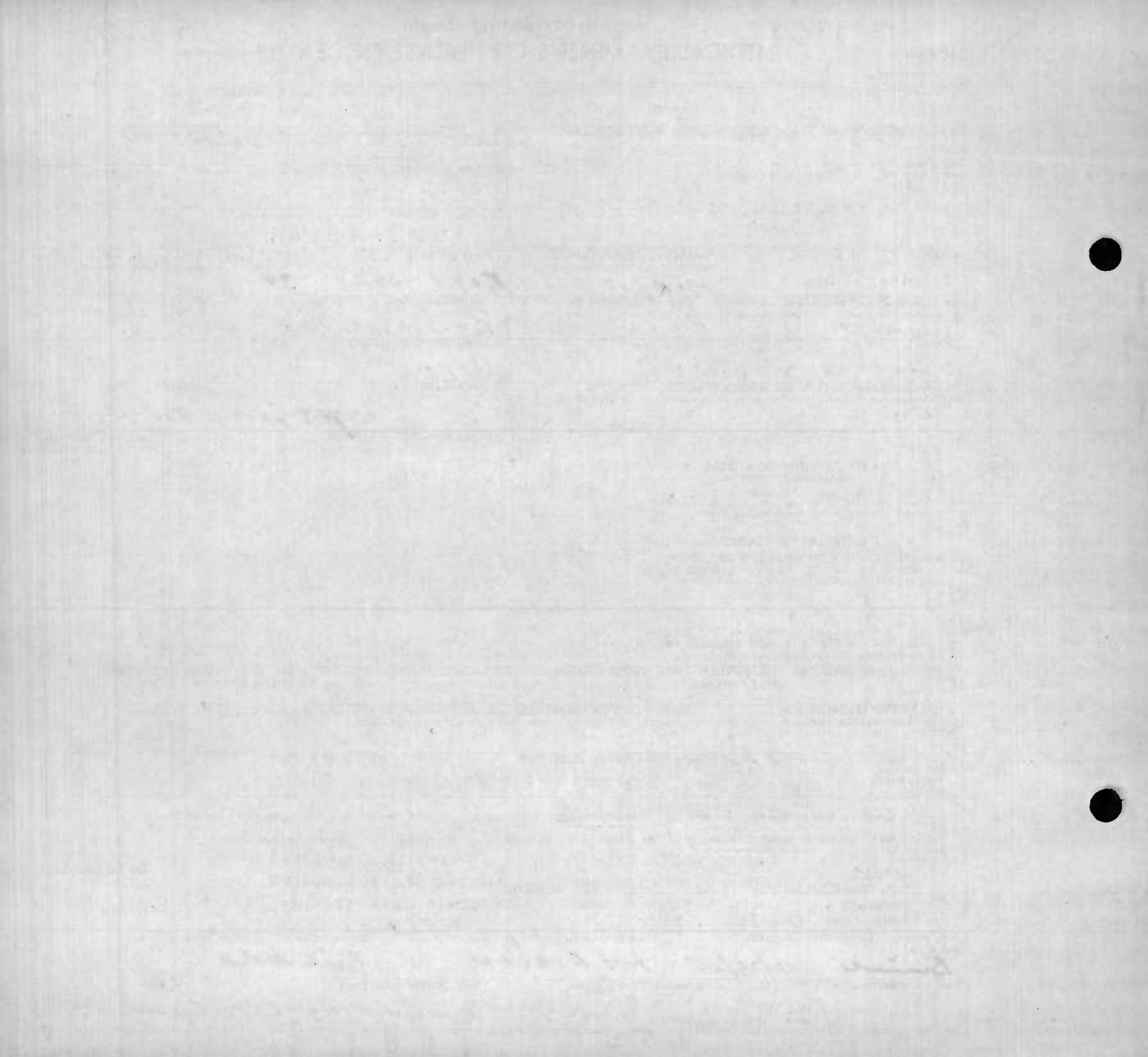
24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Ignace P. Hayes 638 N. Gilman St

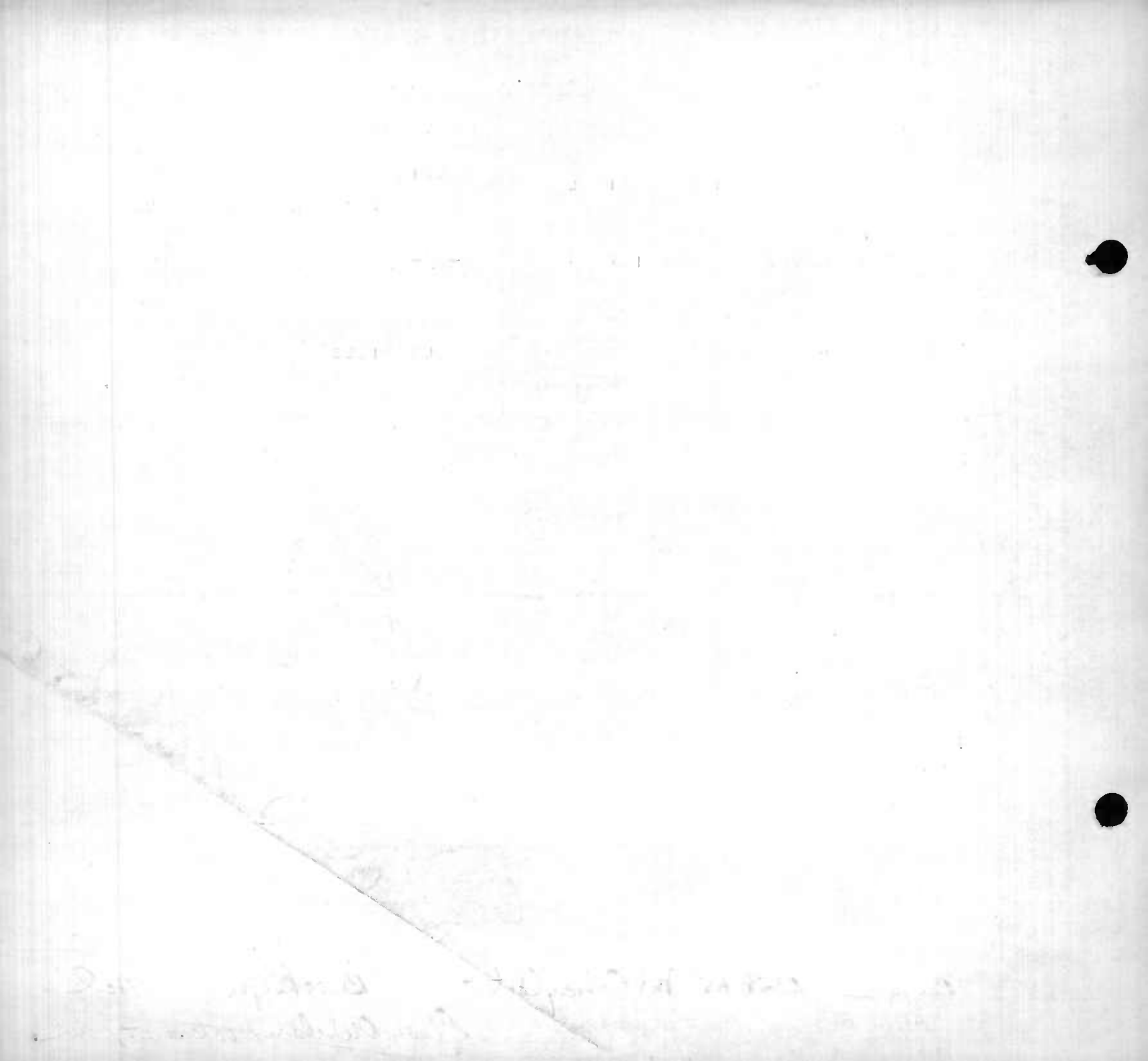
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13272 | |
|---|-------------------------|--|---|--|--|
| BIRTH NO. 65 13272 | | CERTIFICATE OF DEATH | | Registered No. 65 13272 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARY LOUISE JOHNSON | | 2. DATE AND HOUR OF DEATH 12/26/65 15¹⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL | | A. STATE MARYLAND B. COUNTY 8-04 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 1339 PATTERSON PARK AVENUE | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9-23-13 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME LEO GREEN | | | 14. MOTHER'S MAIDEN NAME LULA SILLS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Subarachnoid hemorrhage DUE TO (B) Hypertension DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 day years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/26 1965 to 12/26 1965 , that (I) (we) last saw the deceased alive on 12/26/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Gino V. Segre | | | | 23B. DATE SIGNED 12-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) GINO V. SEGRE | | | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-30-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cmt | |
| 24D. LOCATION (City, town, or county) (State) Brooklyn Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS Elroy O. Nelson 1000 [Address] | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13273 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13273 | |
|---|------------------|--|------------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MARIGENE TATE | | | | 2. DATE AND HOUR OF DEATH 12.23.65 9:55P | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | | | A. STATE B. COUNTY BALTIMORE MD 12-04 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2215 BARCLAY STREET | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2/28/ 22 | 9. AGE (In years last birthday) 43 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Spartanburg, S.C. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME SAM JACKSON | | | |
| 14. MOTHER'S MAIDEN NAME MARIE ANDERSON | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Rotat Late | | | |
| 18. 4-16X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Congestive Heart Failure DUE TO Rheumatic Heart Disease (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12.22 19 65 to 12.23 19 65, that (I) (we) last saw the deceased alive on 12.23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Herman K. Gold | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12.23.65 | |
| 23C. PHYSICIAN'S NAME (Type) Herman K. Gold | | | | 23D. ADDRESS Johns Hopkins Hospital 601 N BROADWAY 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 12-27-65 Burial | | | | Mt Anteburne Cent | | Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR R. L. B. B. | | 25C. FUNERAL DIRECTOR Clayton Wilson on Bantype | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13274 | |
|---|--|--|--|--|--|
| 65 13274 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | Rosealee Johnson | |
| 2. DATE AND HOUR OF DEATH | | 12/26/65 2:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| | | Md Baltimore 15-12 | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| F | | N | | | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 9/10/18 | | 47 | | Housewife | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Baltimore Delaware | | U.S. | | Clay Coe | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Rosa Sawyer | | N. | | | |
| 17. INFORMANT | | ADDRESS | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | |
| James Johnson | | Same | | Acute | |
| | | | | (A) Due to | |
| | | | | Multiple pulmonary fibrosis | |
| | | | | (B) Due to | |
| | | | | (C) | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | 6 hours | |
| | | | | ANTECEDENT CAUSES | |
| | | | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | |
| | | | | II | |
| | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| | | | | Fibrocavitary pulmonary tuberculosis active, advanced | |
| | | | | 10 years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/26 19 65 to 12/26 19 65, that (I) (we) last saw the deceased alive on 12/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| R. L. Corman | | | | 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12-31-65 | | Mt Auburn Cml | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| Baltimore Md | | 01 | | Chapman - 1000 Broadway Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 28 1965 | | 01 | | | |

Letter from MRR at Sinai & amended death cert. signed by Dr. Donald Rice 6/29/66

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13275 | |
|---|---------|--|---|--|--|
| M.E. CASE NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| EFFIE GREEN | | | December 27, 1965 7:35 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| JOHNS HOPKINS HOSPITAL | | | Maryland | | |
| | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 1605 Harford Avenue | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Female | Negro | Widow | Sept 10 - 1908 | 57 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Maile | | | | Shelby North Carolina | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Samuel Wilson | | | USA | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | | | Uma Rountree Same |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | (C) DUE TO | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 12-27-65 | |
| Russell S. Fisher, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12-30-65 | | Mt Calvary Cal | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | |
| DEC 28 1965 | | Robert E. Fisher, M.D. | | Eloy Wilson 1000 Brantly Ave | |
| | | | | ADDRESS | |

1912
JAN 11 - 1912

1912
JAN 11 - 1912

1912
JAN 11 - 1912

1912
JAN 11 - 1912

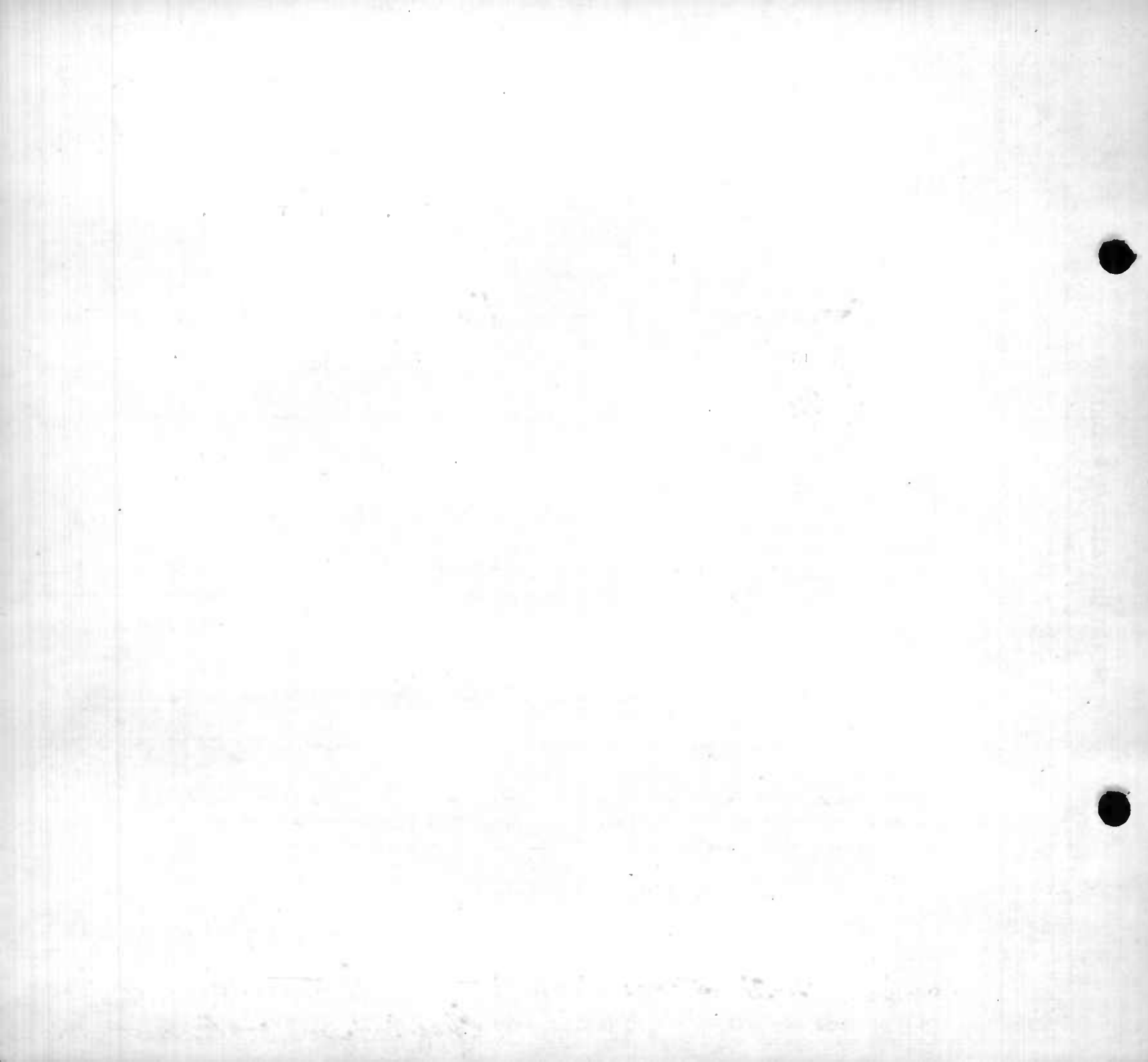
1912
JAN 11 - 1912

1912
JAN 11 - 1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

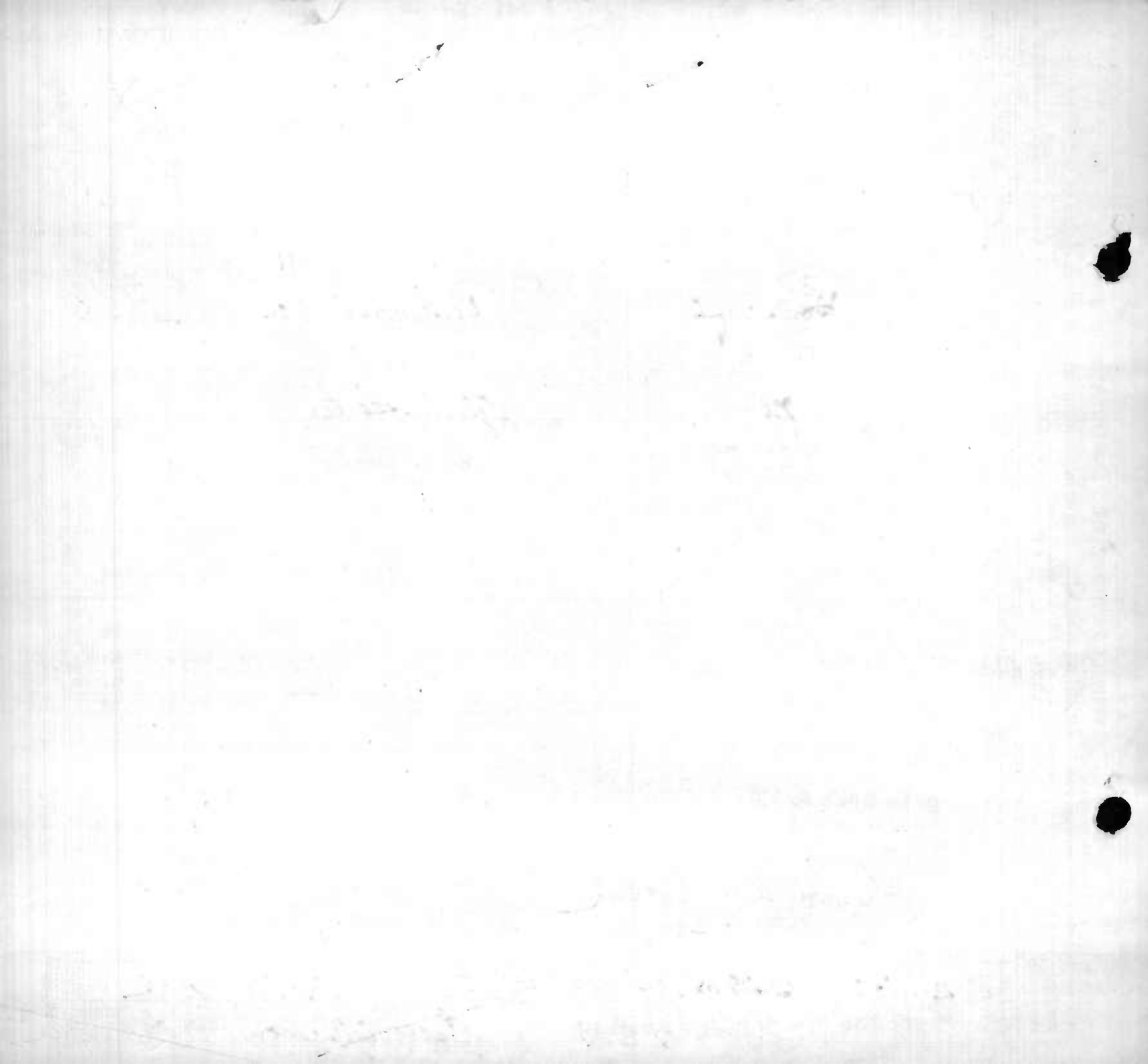
| BIRTH NO. 65 13276 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13276 | |
|--|-------------------------|---|---|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ALLENER WALLACE | | | | 2. DATE AND HOUR OF DEATH 12/23/65 10 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2002 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2345 W. LEXINGTON ST. | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 9-28-03 | 9. AGE (In years lost birthday) 62 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Daniedgewater Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
| 13. FATHER'S NAME ANDREW WHITE | | | 14. MOTHER'S MARDEN NAME MARY ROBERTS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARDIAC Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction ASCUD | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 6 mins. 7 hours ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that it (this hospital) attended the deceased from 12/23 1965 to 12/23 1965 , that it (we) lost saw the deceased alive on 12/23 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. it (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE W. H. Spencer III | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) W. H. SPENCER III | | | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 12-28-65 | | 24C. NAME OF CEMETERY or CREMATORY Green Acres Cmt | | 24D. LOCATION (City, town or county) (State) Eastern Shore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. [unclear] | | 25C. FUNERAL DIRECTOR ADDRESS Chas. [unclear] 1000 Brantley Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

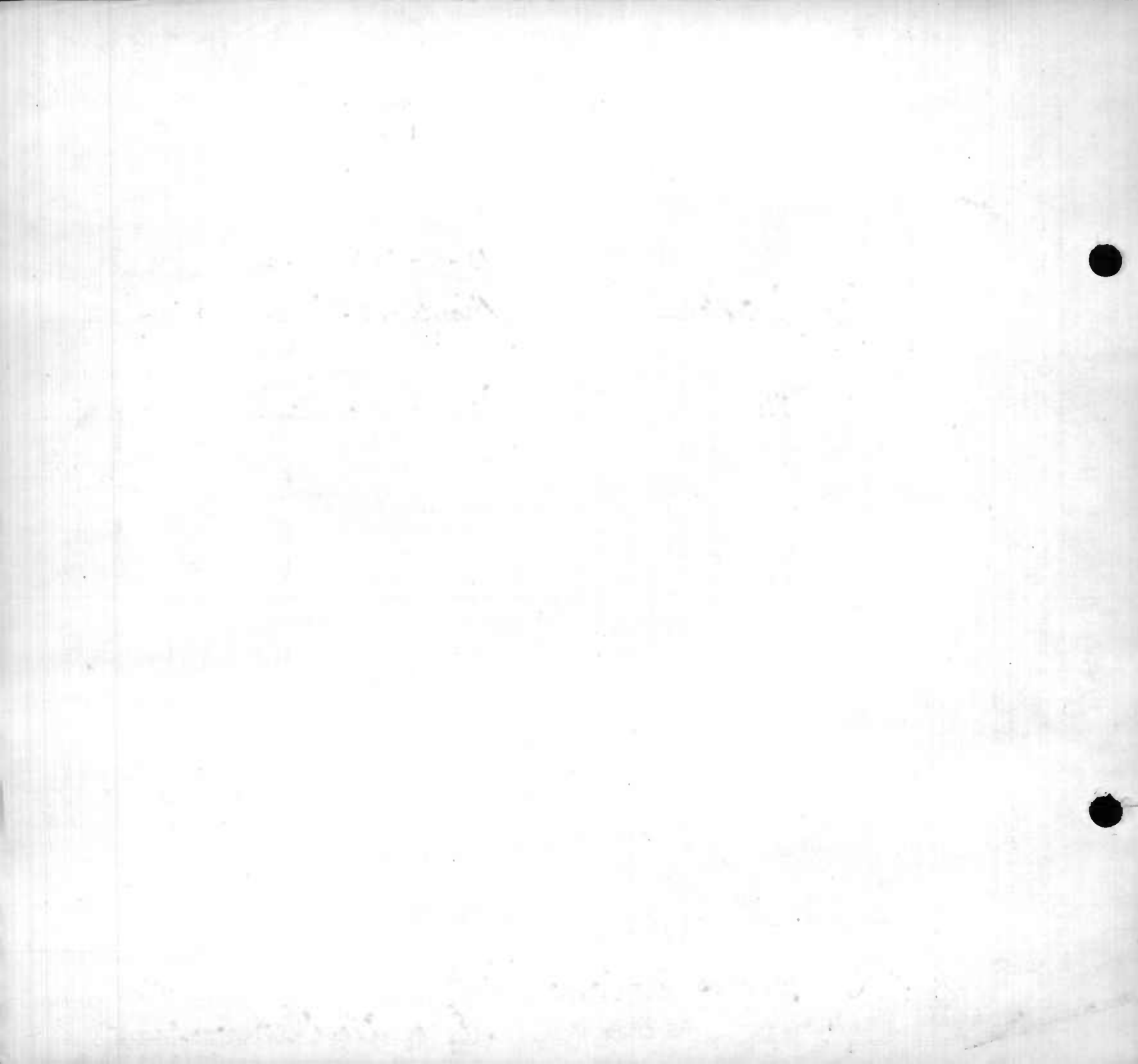
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 13277</u> | |
|--|-------------------------|---|------------------------------------|---|--|
| BIRTH NO. <u>65 13277</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>IRENE WILLIAMS</u> | | 2. DATE AND HOUR OF DEATH <u>12.23.65</u> <u>9:05P</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>601 N BROADWAY 21205</u> | | A. STATE <u>MD</u> B. COUNTY <u>JOPLA RD AVE 25-32</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE MD 21225</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED <u>WIDOW</u> | 8. DATE OF BIRTH <u>5/15/24</u> | 9. AGE (In years last birthday) <u>41</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Richmond Va</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>HENRY TUTT</u> | | 14. MOTHER'S MAIDEN NAME <u>ELLA FOSTER</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Gladys Lester</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Subarachnoid Hemorrhage</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES.</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12.20</u> 19 <u>65</u> to <u>12.23</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12.23</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Herman K. Gold</u> M.D. | | | | 23B. DATE SIGNED <u>12.23.65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HE Herman K. Gold</u> | | | | 23D. ADDRESS <u>Johns Hopkins Hospital</u> M.D. <u>601 N BROADWAY 21205</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-29-65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1965</u> | | 25B. NAME OF REGISTRAR <u>John E. Wilson</u> | | 25C. FUNERAL DIRECTOR <u>John E. Wilson</u> | |
| | | | | ADDRESS <u>Baltimore</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 13278 | |
|---|--|---------------------|---|-------------------------|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED | |
| | | 65 13278 | | Robert Jones | |
| 2. DATE AND HOUR OF DEATH | | 12/23/65 11:40 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | | BALTIMORE MD 6-04 | | |
| 5. SEX | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| MALE | | | 1909 E. JEFFERSON STREET | | |
| 6. RACE | | | D. STREET ADDRESS (If rural, give location) | | |
| NEGRO | | | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | 8. DATE OF BIRTH | | |
| WIDOWER | | | 10-7-1903 | | |
| 9. AGE (In years last birthday) | | | 10. BIRTHPLACE (State or foreign country) | | |
| 62 | | | Blackstock, S. Carolina | | |
| 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| IKE JONES | | | MINNIE WALKER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| No | | | | | |
| 17. INFORMANT | | | ADDRESS | | |
| Willie Mae Stewart | | | Same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) DUE TO | | |
| II | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 2 months | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 0 | | | NO | | |
| 19A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 20A. AUTOPSY? (Yes or No) | | |
| | | | NO | | |
| 21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21F. HOW DID INJURY OCCUR? | | |
| (Month) (Day) (Year) (Hour) | | | | | |
| 21E. INJURY OCCURRED | | | | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/22/65 to 12/23/65, that (I) (we) last saw the deceased alive on 12/23/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| E. Eugene Page | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| E. EUGENE PAGE | | | 601 N BROADWAY | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE | | |
| Burial | | | 12-27-65 | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | |
| Mt Calvary Cmt | | | Baltimore Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | |
| DEC 28 1965 | | | O. E. Johnson | | |
| 25C. FUNERAL DIRECTOR | | | ADDRESS | | |
| Chas. G. Wilson | | | 1001 E. Pratt St. | | |



BIRTH NO.

65 13279

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

POWELL Jr

2. DATE AND HOUR PRONOUNCED DEAD

December 27, 1965

12:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3801 Bonner Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Feb 26 1903

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Powell Sr

14. MOTHER'S MAIDEN NAME

Sallie Powelle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS aag. ml

Clyde Powell 5802 Belgrave Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of the stomach with
DUE TO metastasis of the liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-27-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-31-65

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cal

23D. LOCATION (City, town, or county) (State)

Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

24B. NAME OF REGISTRAR

R. S. Fisher

24C. FUNERAL DIRECTOR

Choy Wilson - 1000 Brandy Ln

ADDRESS

VIA AIR MAIL
JAN 10 1917
OFFICE

W. H. H. H.
W. H. H. H.
W. H. H. H.

W. H. H. H.

W. H. H. H.
W. H. H. H.
W. H. H. H.

BIRTH NO. 65 13280

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY

CRAWLEY

2. DATE AND HOUR PRONOUNCED DEAD

December 26, 1965 10:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2302 E. Federal Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

Sept. 6, 1880

9. AGE (In years
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George H. Thompson

14. MOTHER'S MAIDEN NAME

Rose H. A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Estella Turner

ADDRESS

Same

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-27-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-30-1965

23C. NAME of CEMETERY or CREMATORY

MT. CALvary C.

23D. LOCATION

(City, town, or county)

Brooklyn

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

F. B. Wilson

ADDRESS

1000 Brantley Ave.

W

Page

Michael

Baron 12-2-1910 Mt. Lebanon Co. Pa.
F. B. Wright - 10-10-1910

1

65-13281

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65-13281

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ALBERT NOLLIE

2. DATE AND HOUR PRONOUNCED DEAD December 26, 1965 11:00A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1005 Edmondson Avenue

5. SEX Male

6. RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE

8. DATE OF BIRTH 6-29-1920

9. AGE (in years last birthday) 45

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ebony, VA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Arthur L. Nollie

14. MOTHER'S MAIDEN NAME Lucy House

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) Yes WW II

16. SOCIAL SECURITY NO. 225-26-424

17. INFORMANT L. Northington

ADDRESS 59 Park Ave. Hubert n.J.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 12-27-65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

23B. DATE 12-30-65

23C. NAME OF CEMETERY or CREMATORY BA No. NAT.

23D. LOCATION (City, town, or county) (State) BA No. Md.

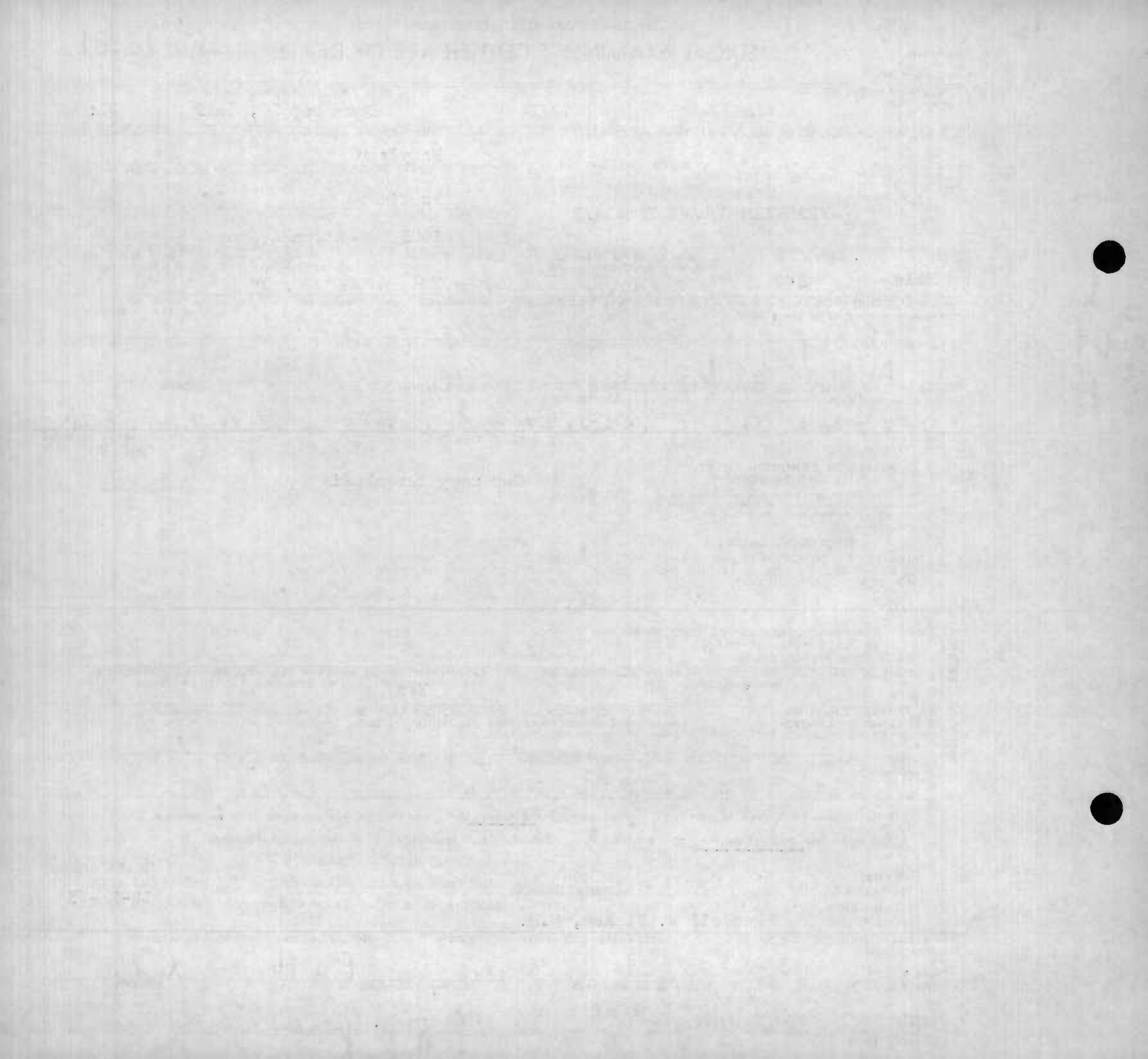
24A. DATE REC'D BY HEALTH DEPT. DEC 28 1965

24B. NAME OF REGISTRAR E. Fisher

24C. FUNERAL DIRECTOR MORTON LOVETT

ADDRESS 1701 Laurens St.

VS 151-REV. 1/1/65



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PERRY KLUTZ

2. DATE AND HOUR PRONOUNCED DEAD

24 December 1965 4:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1035 Somerset St.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

11-25-95

9. AGE (in years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Klutz

14. MOTHER'S MAIDEN NAME

Laura Cruse

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Cora White China Grove, N.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/25/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-31-65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

24B. NAME OF REGISTRAR

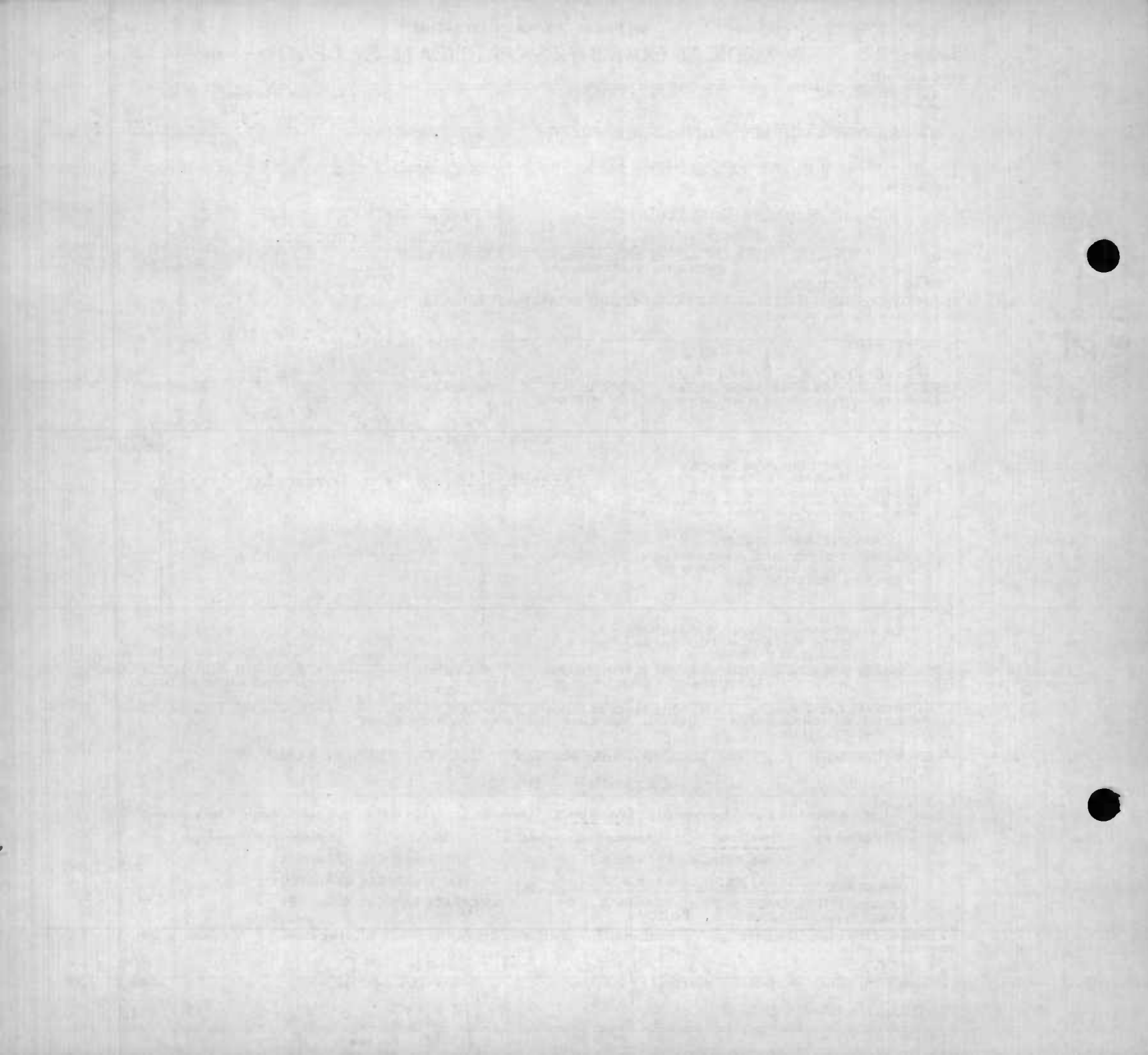
Robert E. Farber

24C. FUNERAL DIRECTOR

Morton & Dyett

ADDRESS

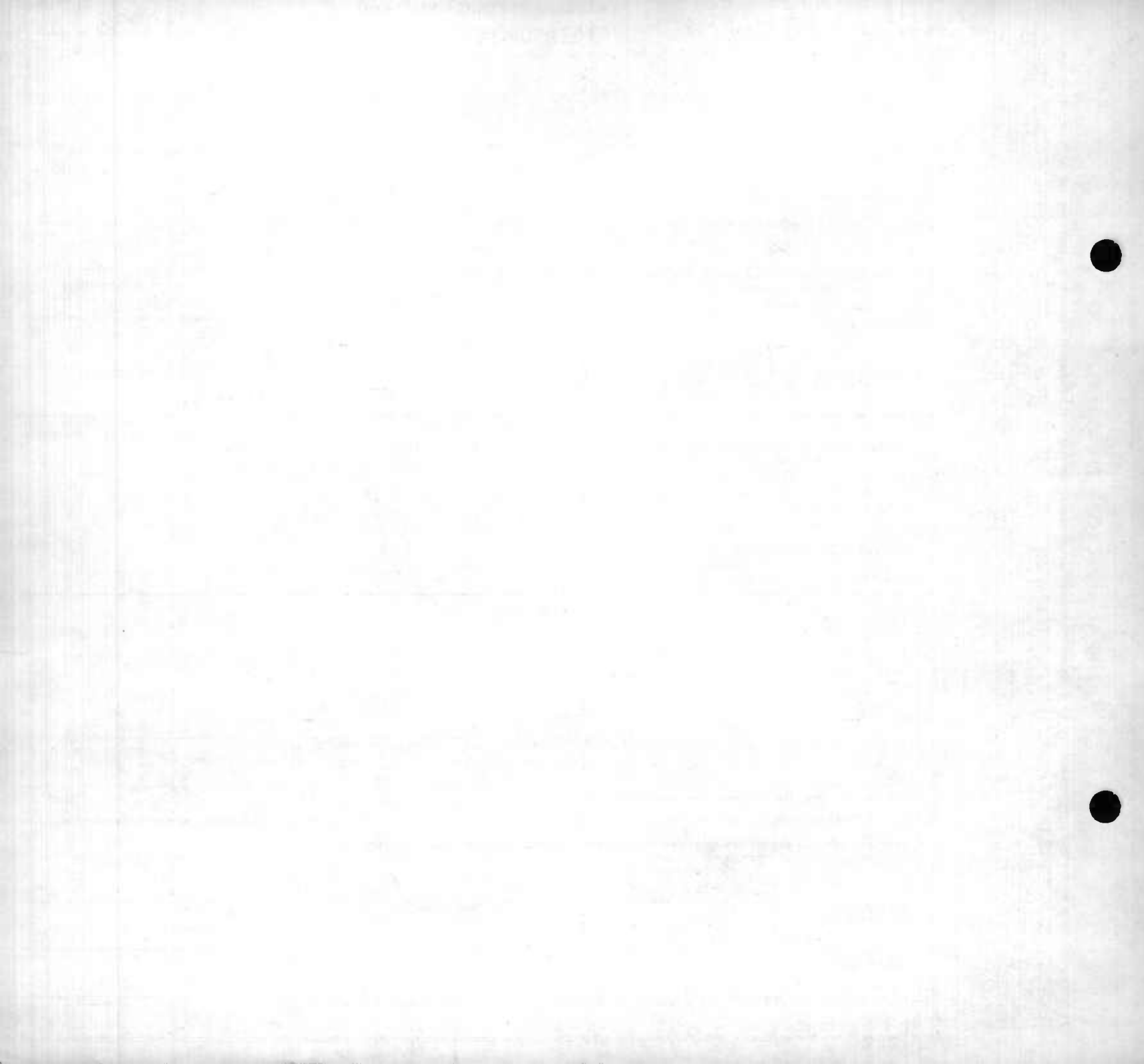
1701 Laurens



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13283 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13283 | |
|--|---------------------|--|--------------------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>MURRAY, Clarence</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/24/65</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>md</i> | | B. COUNTY <i>8-05</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>1737 Oakley Ave</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>11/1/1887</i> | 9. AGE (In years last birthday) <i>78</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Charles Murray</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Emma Murray</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Louis Murray</i> | | ADDRESS <i>1611 Smallwood St.</i> | |
| 18. <i>65 X I</i> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO <i>Pulmonary Hypertension</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO <i>Multiple Pulmonary Emboli</i> | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>25</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (qualify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/19/65</i> to <i>12/24/65</i> , that (I) (we) lost saw the deceased alive on <i>12/24/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Leonard J. Heitzberg</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-24-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Leonard J. Heitzberg</i> | | | | 23D. ADDRESS <i>Sinai Hosp Baltimore, Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/29/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mt. Calvary Cem</i> | | 24D. LOCATION (City, town, or county) (State) <i>Ann Arundel Cty., Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | 25B. NAME OF REGISTRAR <i>John J. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>WM. C. MARCH</i> | | ADDRESS <i>928 E. North Ave</i> | |



65 13284

BALTIMORE CITY HEALTH DEPARTMENT

65 13284

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN MACIOCH

2. DATE AND HOUR PRONOUNCED DEAD

12/23/65 10:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

418 E. Randall St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 16, 1902

9. AGE (In years
lost birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Long shaver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Paul Macioch

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-03-4894 Adam Macioch Box 206 Route 5 Pasadena Md.

17. INFORMANT

ADDRESS

18. E903.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Craniocerebral injury with subdural hematoma

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN IDENTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1500 Blk. Riverside Ave. 24-04

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) about
12 23 65 8:40 p.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

fell on pavement

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/24/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/28/65

23C. NAME OF CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Pawnee Prindel Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Charles L. Stevens Funeral Home, Inc.

ADDRESS

1506 E. Fort Ave

WILLIAM H. ROBERTS

PARSONS

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--------------|---|-------------------------------|
| BIRTH NO. 65 13285 | | REGISTERED NO. 65 13285 | |
| M.E. CASE NO. | | BALTIMORE CITY HEALTH DEPARTMENT | |
| 1. NAME OF DECEASED (Type or Print) Alice O'Connor Moisan | | 2. DATE AND HOUR OF DEATH 12-26-65 1:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 910 E. Belvedere Ave. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-48 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 910 E. Belvedere Ave. | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2/22/1899 |
| 9. AGE (In years lost birthday) 66 | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles V. O'Connor | | 14. MOTHER'S MAIDEN NAME Margaret Harty | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-46-0801 | |
| 17. INFORMANT Col. Philip K. Moisan | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH Carcinoma of breast INTERVAL BETWEEN ONSET AND DEATH 5 yrs | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 1960 to Dec 26 1965, that (I) (we) last saw the deceased alive on Aug 1963 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Thurston R. Adams | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) Thurston R. Adams | | 23D. ADDRESS 3810 Greenway | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/1965 | |
| 24C. NAME OF CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | |
| 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Balto. 12, Md. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13286 | |
|---|---------------------|--|---|---|---|
| BIRTH NO. 65 13286 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Albert Patterson</i> | | 2. DATE AND HOUR OF DEATH <i>Dec. 23 1965 11¹⁵ a.m.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>27-17</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21215</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Bolton Hill Nursing Center</i> | | D. STREET ADDRESS (If rural, give location) <i>2917 2 Hammond Ave</i> | | THORNDALE | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>July 12 1889</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>P.A. R.R.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Francis Patterson</i> | | 14. MOTHER'S MAIDEN NAME <i>Bertha Seymour</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>717-07-8973</i> | | 17. INFORMANT ADDRESS <i>Mr. Charles B. 137 Patterson Chase Rd</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>332X 1 + 260X</i> | | CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Cerebral arteriosclerosis</i> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>25 years</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i> | | <i>unknown</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/13</i> 19 <i>65</i> to <i>12/23</i> 19 <i>65</i> , that (I) (was) last saw the deceased alive on <i>12/18</i> 19 <i>65</i> and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Stanley Z. Felsenberg</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/23/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>STANLEY Z. Felsenberg</i> | | 23D. ADDRESS M.D. <i>1129 E. Baltimore St Balto 2, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/27/1965</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Woodlawn Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Balto. Co., Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i> | |
| 25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i> | | 25D. ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13287 | |
| BIRTH NO. 65 13287 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) IRWIN D. RIDGELY, M.D. | | 12-28-65 12:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL | | A. STATE MARYLAND B. COUNTY 27-13 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) 202 Edgevale Rd. | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-22-92 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY MEDICAL | 9. AGE (In years last birthday) 73 |
| 13. FATHER'S NAME CHARLES C. RIDGELY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. MOTHER'S MAIDEN NAME RACHAEL MAYNARD | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-44-0559 | |
| 17. INFORMANT FLORENCE S. RIDGELY | | ADDRESS ABOVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 153.81 | | CAUSE OF DEATH (A) Carcinomatous DUE TO (B) Cx of colon DUE TO (C) _____ | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH years years | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 6-30-65 19 to 12-28-65 19, that (H) (we) last saw the deceased alive on 12-28-65 12:55 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE C.A. Cendana | | 23B. DATE SIGNED Dec. 28, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) C.A. Cendana | | 23D. ADDRESS Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-31-65 | |
| 24C. NAME OF CEMETERY or CREMATORY Greenmount | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | |
| 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. | |

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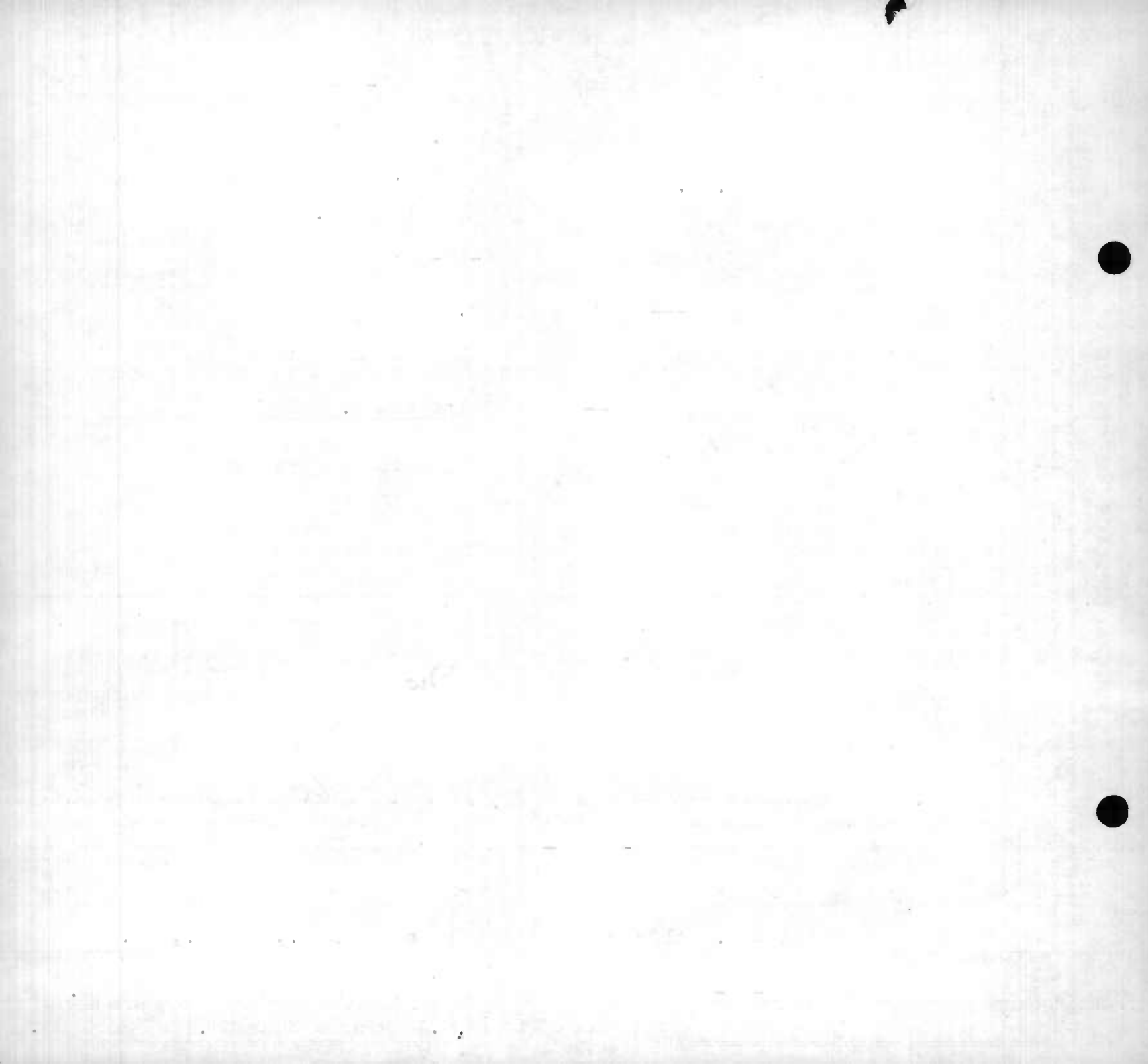
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10-24-12

FUNERAL DIRECTOR: IMPORTANT

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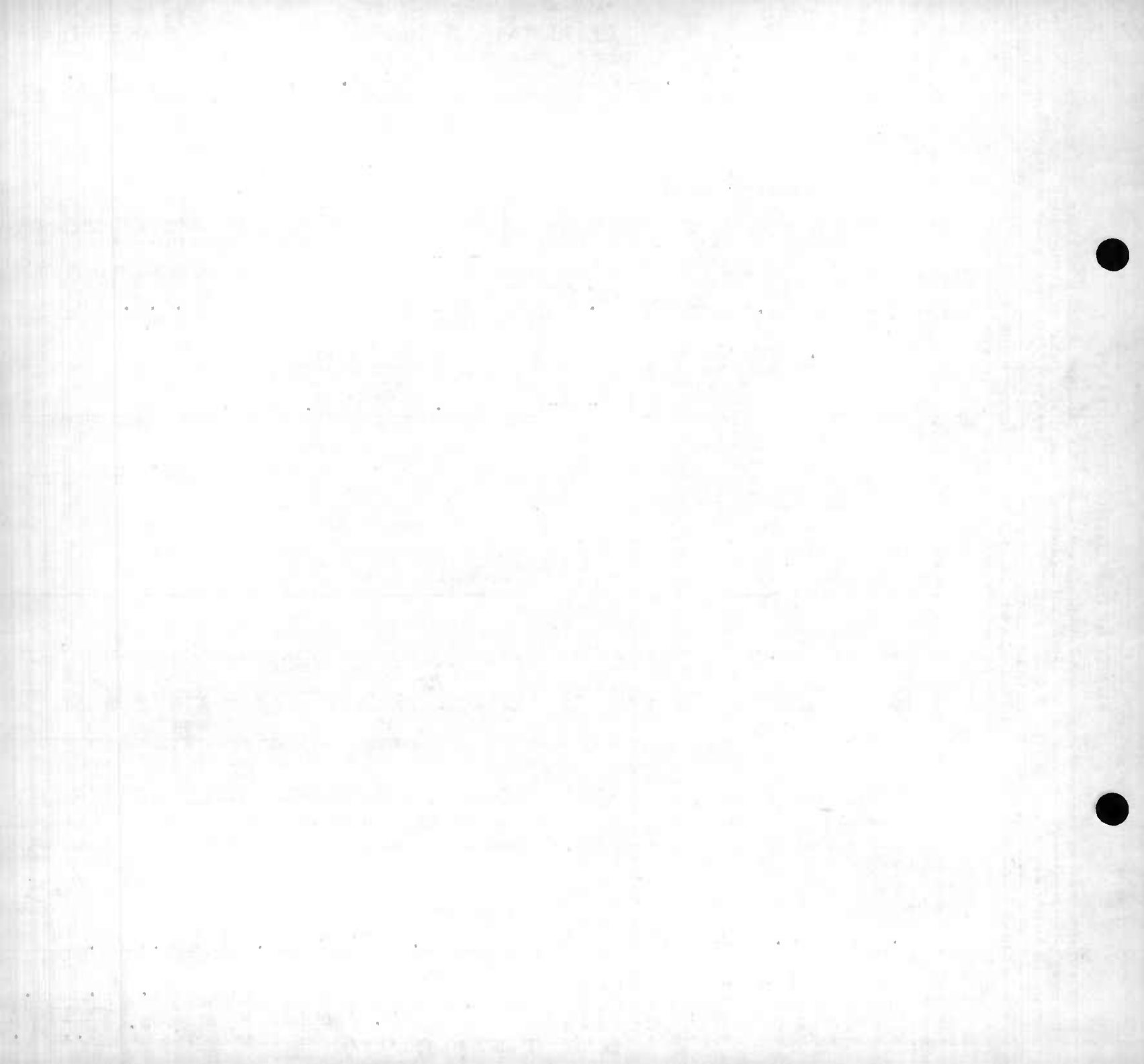
| BIRTH NO. 65 13288 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13288 | |
|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | |
| Janie Osburn Whipple | | | | 2. DATE AND HOUR OF DEATH 12-27-65 3:08 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Md. | | | |
| Edgewood N. H. | | | | B. COUNTY 27-14 | | | |
| 5. SEX F | | | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | |
| 8. DATE OF BIRTH 6-10-1877 | | 9. AGE (In years last birthday) 88 | | 10. UNDER 1 Yr. Months Days | | 11. UNDER 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Employed | | | | 10B. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Morris Osburn | | | |
| 14. MOTHER'S MAIDEN NAME Alberta Pancoast | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. -- | | | | 17. INFORMANT Elizabeth S. Whipple | | ADDRESS Above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis | | | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 11-23-65 to 12-27-65, that (I) (we) last saw the deceased alive on 11/27/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE W. G. Helfrich | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) William G. Helfrich | | | | 23D. ADDRESS 5006 Roland Ave., Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-29-65 | | 24C. NAME OF CEMETERY or CREMATORY Union | | 24D. LOCATION (City, town, or county) (State) Leesburg Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

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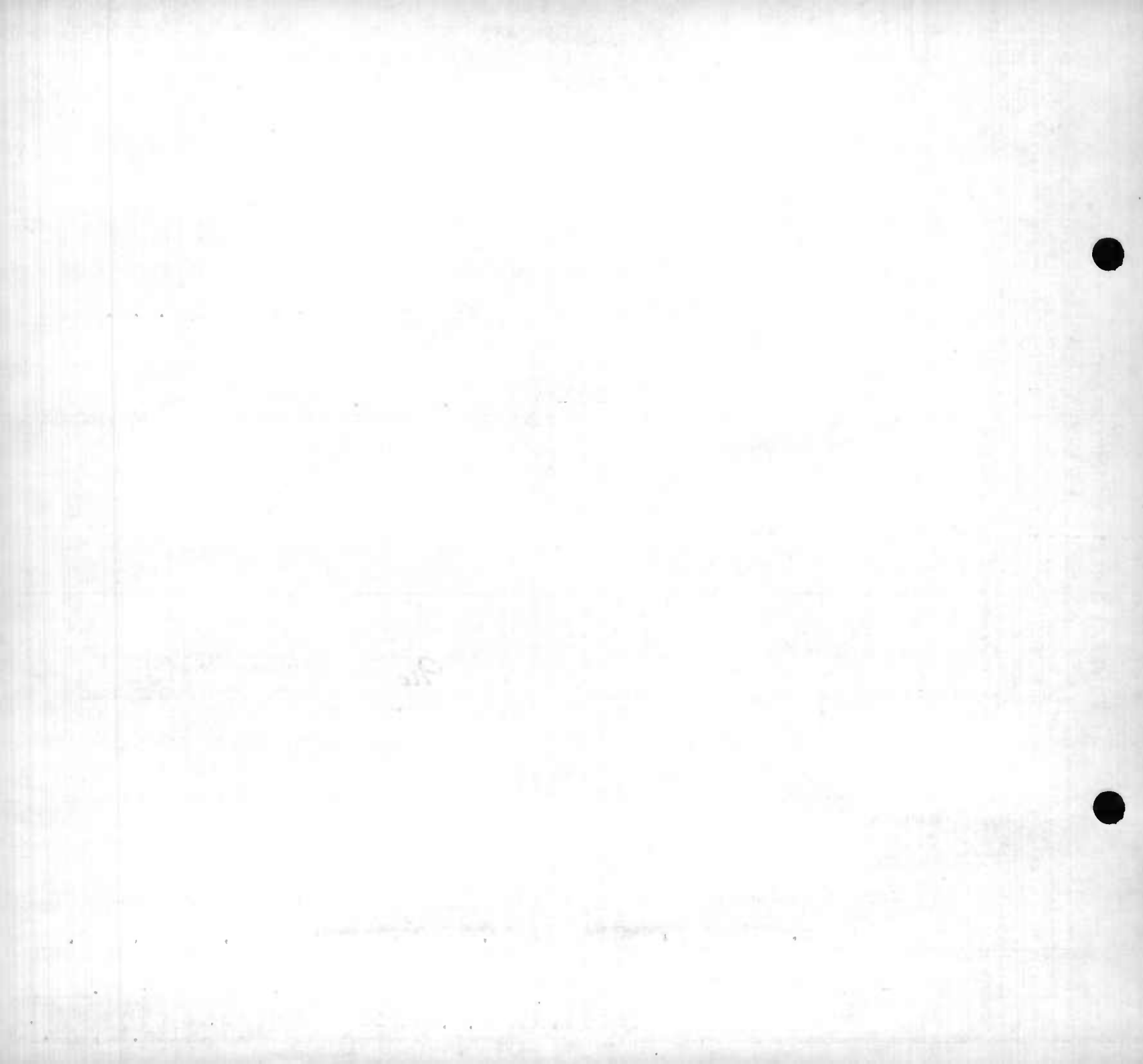
| BIRTH NO. 65 13289 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13289 | |
|--|---------|--|-----------------------------------|--|---|--|------------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Charles T. Howard | | Dec. 24, 1965 9:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HDSPITAL DR INSTITUTION (If not in hospital or institution, give street address or location) | | | | Maryland | | 27-11 | |
| 4308 Wendover Road | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | | | 4308 Wendover Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours |
| M | W | Married | 7-29-1879 | 86 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| President Ret'd. | | | Colonna Howard Lumber Co. | | Maryland | | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Mordecai T. Howard | | | | Harriett Wood | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS |
| No | | | 220-05-7990 | | Mrs. Muriel B. Howard | | Same |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | 1 week | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 24</u> 19 <u>65</u> to <u>Dec 24</u> 19 <u>65</u> , that (I) <u>was</u> lost saw the deceased alive on <u>Dec 24</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Dr. Edwin J. Berstock | | | | 23D. ADDRESS | | 2212 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | | | 12-28-1965 | | Druid Ridge Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 28 1965 | | | | Robert E. Jenkins | | Henry W. Jenkins & Sons Co. | |
| 25D. LOCATION (City, town, or county) (State) | | | | 25E. ADDRESS | | 25F. ADDRESS | |
| Pikesville, Balto. Co. Md. | | | | 4705 York Road | | Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

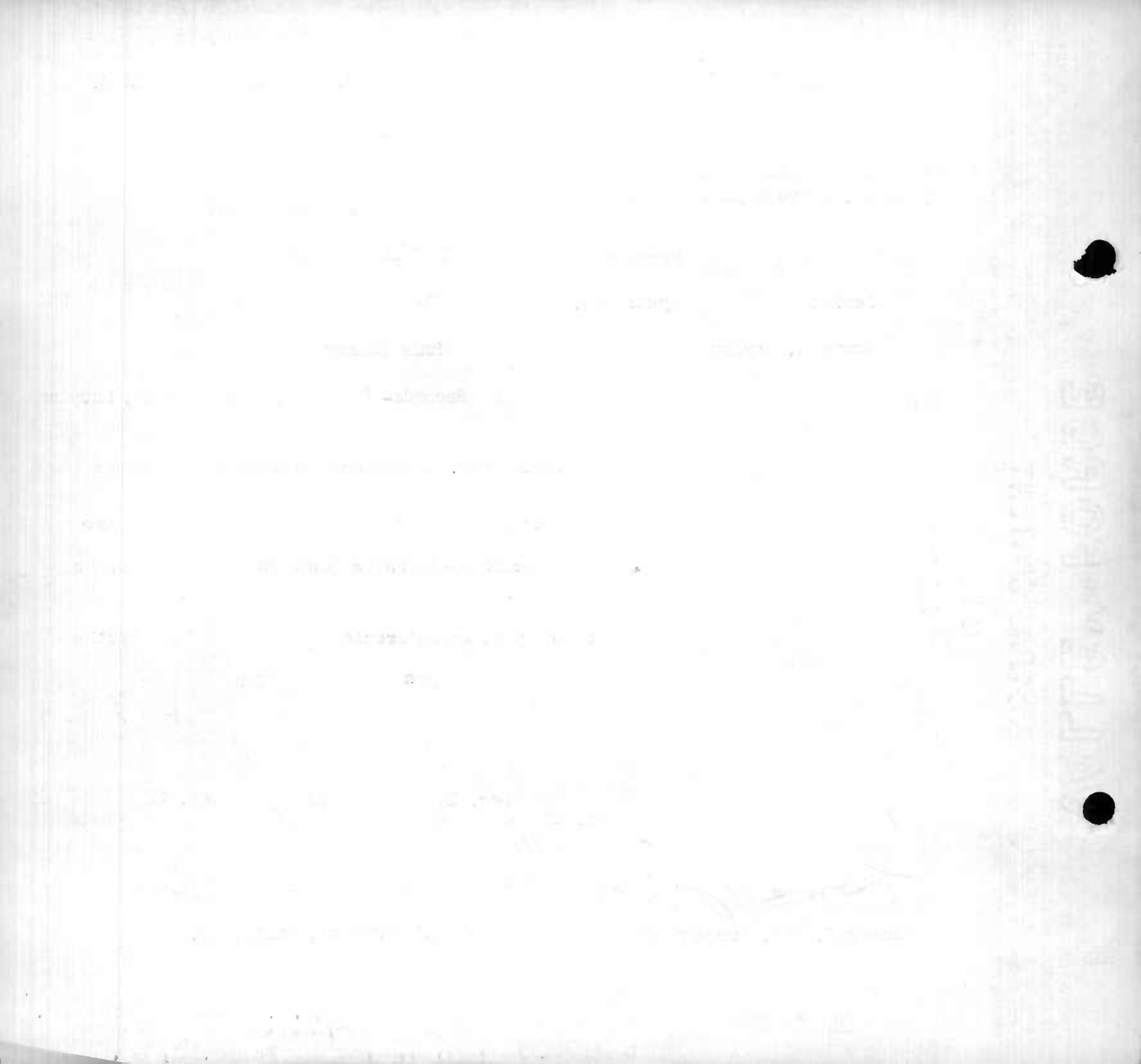
| | | | | | |
|--|--------------|--|-------------------------------|---|--|
| 65 13290 BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13290 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Elfrieda Braun Junker | | December 25, 1965 11:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| 34 Charlcoate Place | | Maryland 27-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 34 Charlcoate Place | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9/15/1885 | 9. AGE (In years lost birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Germany Barmen-Elberfeld, | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Friedrich Braun | | 14. MOTHER'S MAIDEN NAME Johanna | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 461-56-1101 | | 17. INFORMANT ADDRESS Mrs. John N. Peabody (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Myocardial Decomensation (B) DUE TO Hypertension in Arteriosclerosis C.V. Dec. (C) | | INTERVAL BETWEEN ONSET AND DEATH 1408. 1037. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-30 1964 to 12-25 1965, that (I) (we) lost saw the deceased alive on 12-24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wilmer K. Gallagher Dr. | | | | 23B. DATE SIGNED 12-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Dr. Wilmer K. Gallagher, Sr. 6209 Frederick Ave. Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial-Removal | | 12/29/65 | | Pine Grove | |
| 24D. LOCATION (City, town, or county) (State) | | Ansonia, Conn. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 28 1965 | | Robert E. Jenkins | | H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|---|---|--|
| 65 13291 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13291 | |
| BIRTH NO. | | 65 13291 | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| HARRY ARTHUR SAYLOR | | | Dec. 27, 1965 11:45 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | A. STATE Pa. B. COUNTY V-35 | | |
| 5. SEX M | | | 6. RACE W | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | | 8. DATE OF BIRTH 8/20/12 | | |
| 9. AGE (In years last birthday) 53 | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist | | |
| 11. BIRTHPLACE (State or foreign country) Pa. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Harry W. Saylor | | | 14. MOTHER'S MAIDEN NAME Annie Hummer | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None | | | 16. SOCIAL SECURITY NO. ? | | |
| 17. INFORMANT Records- US PHS Hospital, Balto, Maryland | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO Acute gastrointestinal hemorrhage | | | INTERVAL BETWEEN ONSET AND DEATH Hours | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DUE TO (B) Acute gastritis (C) Acute myelogenous leukemia | | | Hours Months | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary atherosclerosis | | | Months | | |
| 21. DATE OF OPERATION 2 | | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 25. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 28. HOW DID INJURY OCCUR? | | |
| 29. I certify that (I) (this hospital) attended the deceased from Dec. 19 1965 to Dec. 27 1965, that (I) (we) last saw the deceased alive on Dec. 27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 30. SIGNATURE <i>Thomas J. Lau</i> | | | 31. DATE SIGNED 12/27/65 | | |
| 32. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R) | | | 33. ADDRESS US PHS Hospital, Balto, Md. | | |
| 34. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial | | 35. DATE 12/31/1965 | | 36. NAME OF CEMETERY or CREMATORY Chiques | |
| 37. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 38. NAME OF REGISTRAR Robert E. Jenkins | | 39. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13292 | |
|---|------------------|--|------------------------------------|--|--|
| BIRTH NO. 65 13292 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Myron Lea Lipton | | 2. DATE AND HOUR OF DEATH December 22, 1965 9 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. B. COUNTY 12-01 | | | |
| 108 W. 39th St. Baltimore, Md. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. | | | |
| | | D. STREET ADDRESS (If rural, give location) 108 W. 39th St. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH March 15, 1914 | 9. AGE (In years last birthday) 51 Yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Treasurer Chemical Service Of Baltio. Inc. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Dallas Texas | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Philip Lipton | | | |
| 14. MOTHER'S MAIDEN NAME Annie Lichtenstein | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. II | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Md. Mrs. Elise C. Lipton, 108 W. 39th St., Baltimore, | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) Carcinomatous Metastases (B) (Amplastic Carcinoma Bladder) (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 months. June 9-1965 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 9 1965 to Dec. 22 1965, that (I) (we) last saw the deceased alive on Dec. 22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bernard J. Cohen | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. BERNARD J. COHEN | | 23D. ADDRESS M.D. The Marylander, Apt. 2 350 1st St., Pikesville, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 24, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | |
| 24D. LOCATION Pikesville 8, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. [unclear] | | 25C. FUNERAL DIRECTOR ADDRESS Frank H. Newell, Pikesville 8, Md. | | | |

Received T. Cohen
Barnes & Co.

Dec. 22, 1892

to Mr. R.



Thompson, Oct. 23 1892

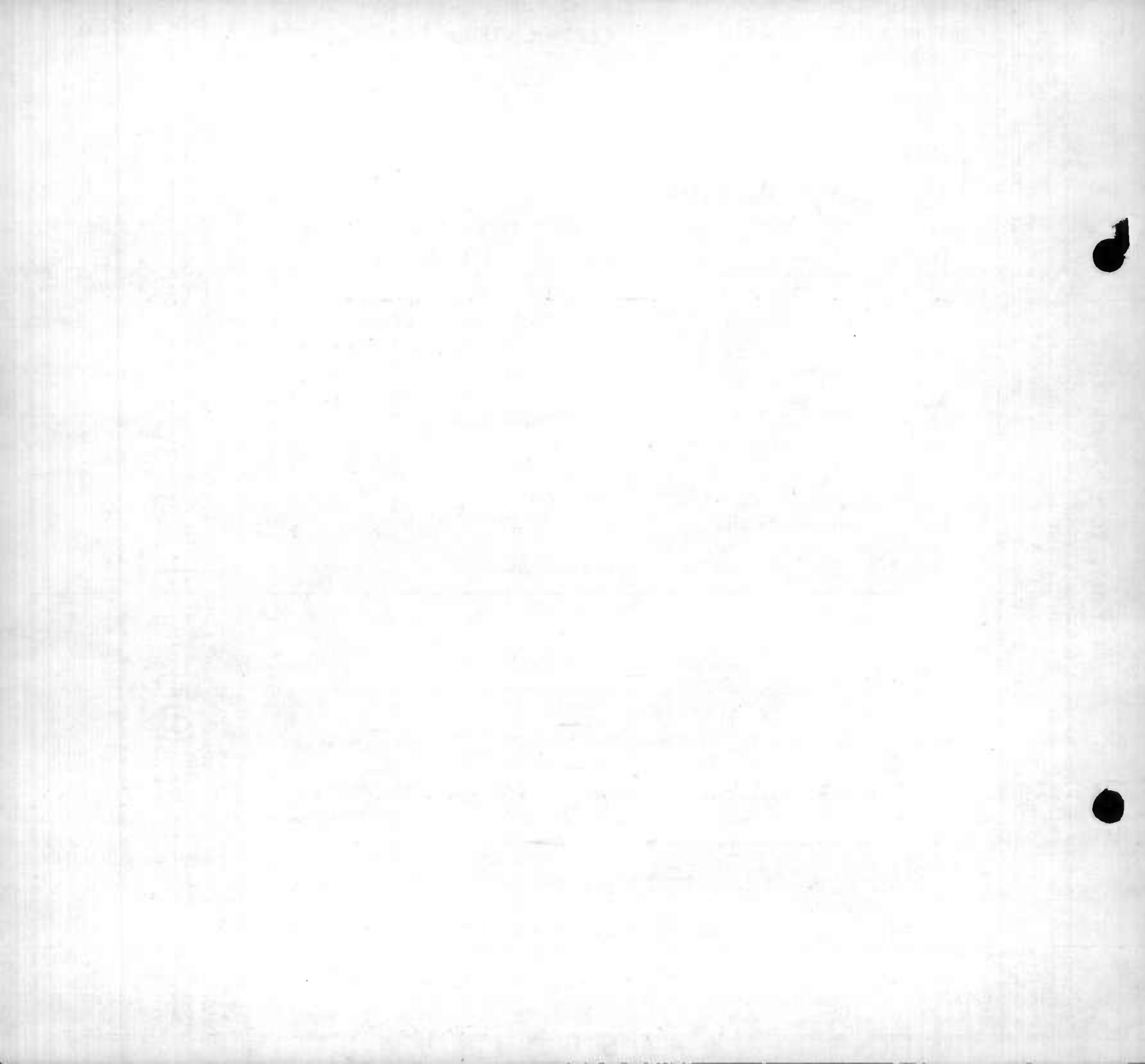
12-25-92

(Opposite Census Bureau Jan 1892)
Census Bureau - Washington

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

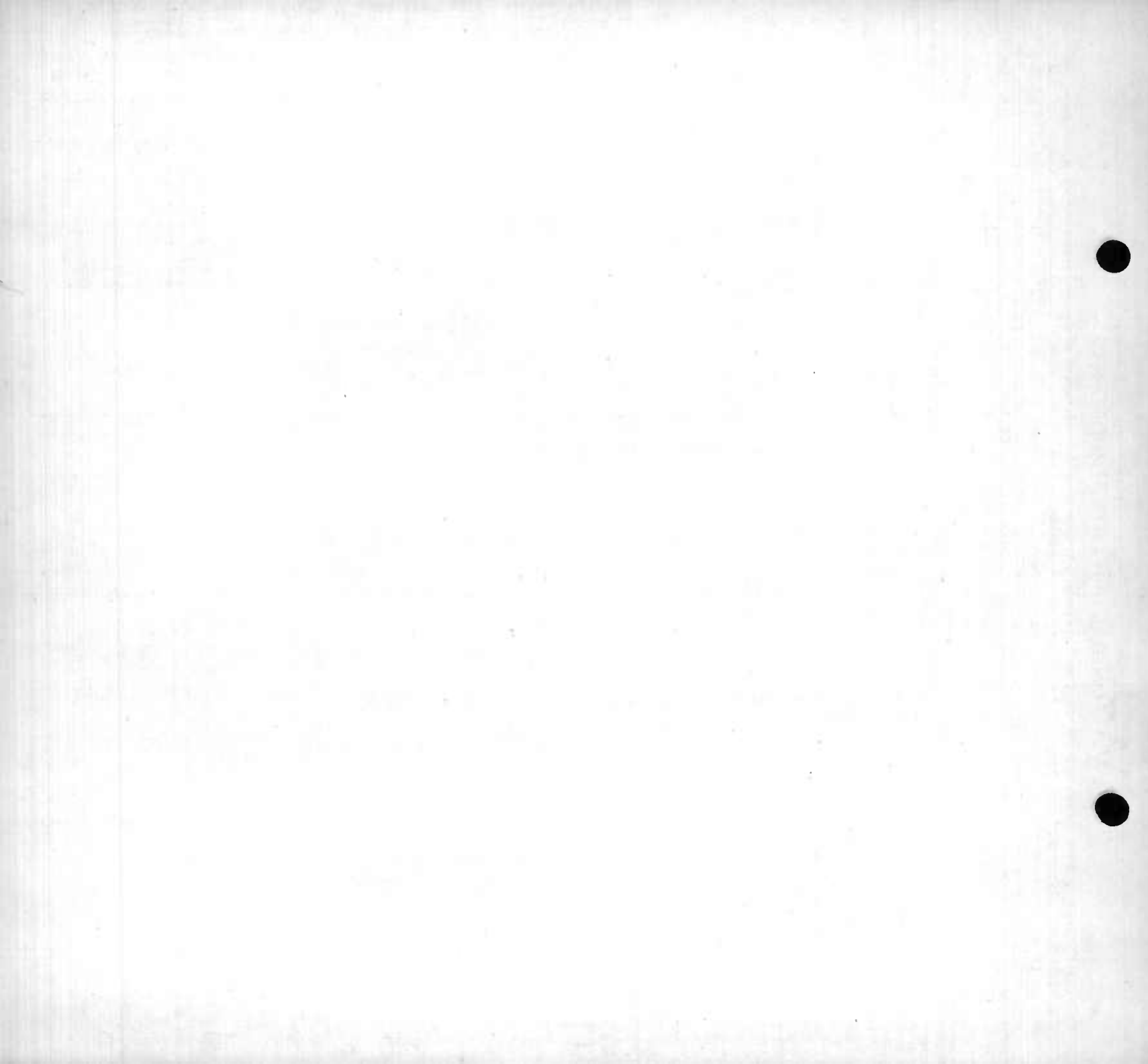
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|--|---------|--|------------------|--|--|
| BIRTH NO. 65 13293 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13293 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. 65 13293 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Reed, Baby Boy | | 20 Dec. 1965 | | 2:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. | | B. COUNTY ANNE ARUNDEL | |
| University Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | GAMBRILLS 52-00 | |
| | | D. STREET ADDRESS (If rural, give location) | | 490 PATUXENT DRIVE | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. |
| Male | Cauc. | Never Married | 19 Dec 1965 | - | - - 5 8 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Newborn | | - | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Richard Reed | | MAUDE PRESTON | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No - | | - | | Chart - Mother | |
| 18. 762.5 - 1 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Neonatal Atelectasis | | 5h - 8 min | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) Prematurity | | L.R. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 None | | - | | - | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| No | | - | | - | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| - | | - | | - | |
| 22. I certify that (this hospital) attended the deceased from 19 December 1965 to 20 December 1965, that (we) last saw the deceased alive on 20 December 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Edward J. Ruley M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 20 Dec 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Edward J. Ruley | | University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | DEC. 22, 1965 | | PORTVILLE CEMETERY | |
| | | | | PORTVILLE N. Y. | |
| 25A. DATE REC'D BY HEALTH DEPT | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 28 1965 | | Robert E. Jenkins, M.D. | | HOPPING FUNERAL HOME | |
| | | | | ADDRESS | |
| | | | | ANNAPOLIS, MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 13294 | |
|--|---------------------|--|---|--|---|
| BIRTH NO. 65 13294 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | Registered No. 65 13294 | |
| 1. NAME OF DECEASED (Type or Print) <u>Rebecca P. Howard</u> | | | 2. DATE AND HOUR OF DEATH <u>Dec. 25, 1965</u> <u>1135</u> P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>FRANKLIN SQ. HOSPITAL</u> | | | A. STATE <u>BALTIMORE</u> B. COUNTY <u>25-04</u> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>204 WASHBURN AVE.</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify) <u>Married</u> | 8. DATE OF BIRTH <u>JAN 27 1901</u> | 9. AGE (In years last birthday) <u>64</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | |
| 13. FATHER'S NAME <u>UNKNOWN (Franklin Golden)</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN (Gertrude Lynn)</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Family</u> | |
| 18. <u>199.21</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO <u>Carcinoma of the</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>Dec. 25/65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 14</u> 19 <u>65</u> to <u>Dec. 25</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec. 25</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>S. B. League</u> | | | | 23B. DATE SIGNED <u>Dec. 25, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>SAMUEL B. LEAGUE</u> | | 23D. ADDRESS M.D. <u>FRANKLIN SQ HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-29-65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Green Haven</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Green Haven Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u> | | 25C. FUNERAL DIRECTOR <u>McGilly - 237 Patapsco Ave</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|----------------------|--|--|--|---|
| BIRTH NO. 65 13295 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13295 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>POTEET, BENEDICT J.</i> | | | | | |
| 2. DATE AND HOUR OF DEATH <i>12/26/65 1:50 p.m.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>SOUTH BALTIMORE GENERAL HOSPITAL</i> | | | A. STATE <i>MD</i> B. COUNTY <i>BALTA</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>2700 Yorkway</i> | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>10/2/67</i> | 9. AGE (In years last birthday) <i>1 yr 14 months</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Benedict Poteet, Jr.</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Linda Heppding</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Family home</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | (A) <i>Convulsive - Seizure</i> | | |
| ANTECEDENT CAUSES | | | (B) <i>Intoxication - Alcohol</i> | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) <i>Degenerative Disease of Muscle</i> | | |
| II | | | INTERVAL BETWEEN ONSET AND DEATH <i>43 days</i> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/13/65</i> to <i>12/26/65</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/26/65 (1:50 p.m.)</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Mohamed Mijeeb</i> M.D. | | | | 23B. DATE SIGNED <i>12/26/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| | | | | M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-28-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Cem</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Glen Burnie Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert J. [unclear]</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>McCully J. N. 2370 [unclear]</i> | |

Walt White
General Manager
10/10/12
10/10/12

General Plant, Jr.
Lento Hopping
Baltimore

General Manager
Lento Hopping
Baltimore

No

10/10/12
10/10/12
10/10/12

General Manager

E 645

65 13296

BALTIMORE CITY HEALTH DEPARTMENT

65 13296

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|--|------------------|---|--|--|---------------------------------------|
| 1. NAME OF DECEASED (Type or Print) | | JOHN ERLANDSON | | 2. DATE AND HOUR PRONOUNCED DEAD December 22, 1965 7:31 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2441 Jefferson Street | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH Sept 8, 1896 | 9. AGE (In years lost birthday) 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance | | 10B. KIND OF BUSINESS OR INDUSTRY B. E. K. T. Hoop Sweden | | 11. BIRTHPLACE (State or foreign country) Sweden | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-01-1664 | | 17. INFORMANT Hospital Records | |
| 18. CAUSE OF DEATH 431X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Idiopathic Myocardial Hypertrophy. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, steel, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/22/65 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12-24-65 | | 23C. NAME OF CEMETERY or CREMATORY Catharine | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 24B. NAME OF REGISTRAR Robert E. [unclear] | | 24C. FUNERAL DIRECTOR RAYMOND H. [unclear] ADDRESS | |

1965001

65950-8647

VALLEY FORGE

THE HONORABLE

1777

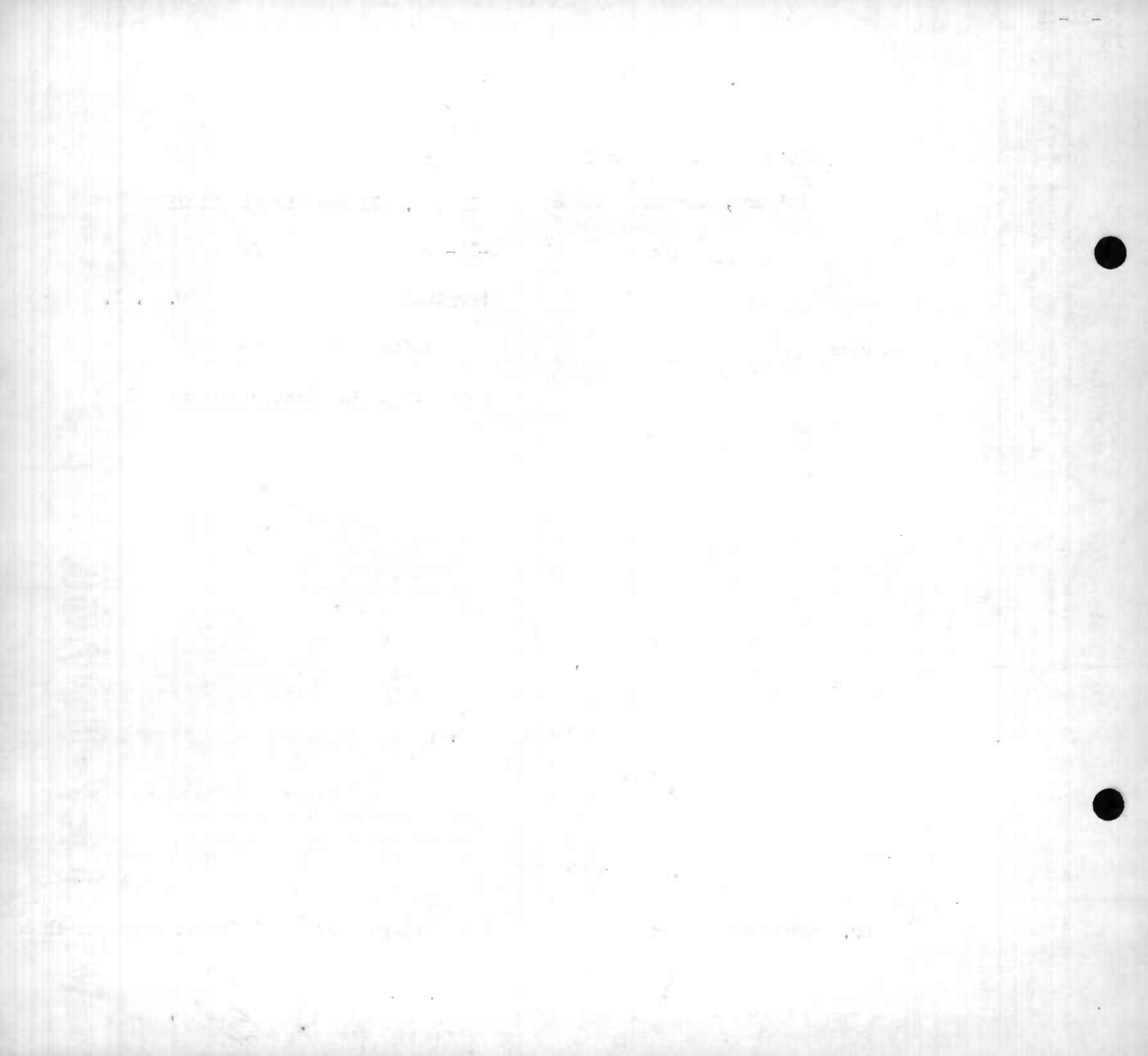
36-24-08

FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13297 | |
|---|------------------|--|-----------------------------------|--|---|
| BIRTH NO. 65 13297 | | CERTIFICATE OF DEATH | | Registered No. 65 13297 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>White Howard</i> | | 2. DATE AND HOUR OF DEATH <i>12/21/65 15 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE <i>Maryland</i> B. COUNTY <i>26-11</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i> | | <i>Baltimore</i> | | <i>1131 S. Clinton Street 21224</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>6-13-1893</i> | 9. AGE (In years last birthday) <i>72</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>City Employee</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Charles W.</i> | | 14. MOTHER'S MAIDEN NAME <i>Caroline Nitze</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 Eastern Avenue 21224</i> | |
| 18. I <i>1778 I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO <i>pneumonia</i> | | <i>1 wk</i> | |
| ANTECEDENT CAUSES | | (B) DUE TO <i>metastatic ca prostate</i> | | <i>years</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/21 1965</i> to <i>12/21 1965</i> , that (I) (we) last saw the deceased alive on <i>12/21 1965</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Harry Dean Albert</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/21/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Dr. Harry Dean Albert</i> | | 23D. ADDRESS <i>4940 Eastern Avenue Baltimore, Maryland 21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12-24-65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Oakland</i> | |
| 24D. LOCATION (City, town, or county) <i>Balto Ct.</i> | | 24E. LOCATION (State) <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Hoffman</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Clarence Hoffman</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13298 | |
|--|--|--|--|---|--|
| BIRTH NO. 65 13298 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WALTER O Rzewolski | | 2. DATE AND HOUR OF DEATH DEC. 26, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1-04 | | | |
| FULL NAME OF HDSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 809 S. Port St | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED (specify) | | 8. DATE OF BIRTH 12-18-1892 | 9. AGE (In years last birthday) 72 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONG SMOKE MAN | | 10B. KIND OF BUSINESS OR INDUSTRY MARITIME | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-09-3268 | | 17. INFORMANT MEDICAL RECORD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I | | CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) Coronary vascular disease DUE TO (C) asphyxia | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-5 19 65 to 12-26 19 65 , that (I) (we) last saw the deceased alive on Dec 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Florence S. de la Merced M.D. | | | | 23B. DATE SIGNED 12-26-65 | |
| 23C. PHYSICIAN'S NAME (Type) FLORENCE S. de la MERCED | | 23D. ADDRESS CHURCH HOME & HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12-29-1965 | 24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM. | | 24D. LOCATION (City, town, or county) (State) BALTIMORE Co. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI | |
| | | | | ADDRESS 2525 FLEET ST | |

Prognosis? when placed

Franses de L. J. J. J.

Check name { 140671

12-20-21

Dec 20 21

at

12-20-21

Under vacuum ~~condition~~

Capacitor from Japan

Project tested

TOUGHER

(over)

THIS UNIT

Check name { 140671

12

65 13299

BALTIMORE CITY HEALTH DEPARTMENT

65 13299

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GERALDINE CURRY

2. DATE AND HOUR PRONOUNCED DEAD

25 December 1965 11:33 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

339 Scott St.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

10/13/41

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William A. Curry

14. MOTHER'S MAIDEN NAME

Evelyn Bowie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Evelyn Curry 339 Scott St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wounds of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

339 Scott St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour) (Min)
Dec. 25, 1965 10:50

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot in head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/26/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/29/65

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Brooklyn, Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

24B. NAME OF REGISTRAR

Robert E. Kelly

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.

VALLEY BORE

WALL GUN

USE

IN

K-140

65 13300

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 13300

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY KAPPEL

2. DATE AND HOUR PRONOUNCED DEAD

12/23/65 4:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

618 N. Clinton St.

4. USUAL RESIDENCE (Where decedent lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

618 N. Clinton St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed

8. DATE OF BIRTH

2 July, 1887

9. AGE (In years
last birthday)

78

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William Brendel

14. MOTHER'S MAIDEN NAME

Francis Decker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

William Brendel, Jr. 4800 Walther Ave. 21214

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/24/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

12-27-65

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

(City, town, or county)

Baltimore County, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 28 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

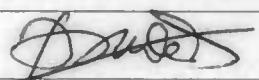
Ullrich Funeral Home, Baltimore, Md.

ADDRESS

WILLIAM H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13301 | |
|---|------------------------------|--|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 13301 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARLENE MEAD | | | 2. DATE AND HOUR OF DEATH 12/23/65 10³¹/P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Franklin Square Hospital FULL NAME OF HOSPITAL OR INSTITUTION <small>(If not in hospital or institution, give street address or location)</small> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 5300 D. STREET ADDRESS (If rural, give location) 3500 Louth Rd. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 10/28/1897 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New York | |
| 13. FATHER'S NAME Nathaniel Cebury | | | 14. MOTHER'S MAIDEN NAME Ida Heverich | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO. | | 16. SOCIAL SECURITY NO. 132-12-9041A | | 17. INFORMANT DELHAM K. MEAD ADDRESS 3500 LOUTH RD | |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARCINOMATOSIS, METASTATIC ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BREAST CARCINOMA, PRIMARY | | | INTERVAL BETWEEN ONSET AND DEATH 18 YRS. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. URINARY TRACT INFECTION | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC. 13 1965 to DEC. 23 1965 , that (I) (we) last saw the deceased alive on DEC. 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/23/65 |
| 23C. PHYSICIAN'S NAME (Type) BENIGNO M. OTEYZA | | | 23D. ADDRESS 415 GILMORE RD. DOPPA, MD. 21085 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12/27/65 | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY COLEGE MD | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR WILLIUGH FUNERAL HOME DUNDALK MD | |

CAUSING MATOSIS
METASTATIC
BREAST CARCINOMA
PRIMARY

PRIMARY TREATMENT

DEC 13 1962

~~SECRET~~

RECEIVED M. OLEYA HIS CHURCH IN, 1962

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|------------------------------|--|---|
| BIRTH NO. 65 13302 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13302 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN M. MILLER | | 2. DATE AND HOUR OF DEATH 12/25/65 12:15A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 3930 BELVIEW AVE | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 12/18/86 | 9. AGE (In years, last birthday) 79 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME JOHN A. MILLER | | 14. MOTHER'S MAIDEN NAME ROSA SCHUH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MISS CARLIE KEIGLER | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO MYOCARDIAL INFARCTION (B) DUE TO Pulmonary Edema (C) DIABETES MELLITUS | | INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days 15 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 12/18/65 to 12/25/65, that (we) lost saw the deceased alive on 12/25/65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert N. Whitlock | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT N. WHITLOCK | | 23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-28-65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore | |
| 24D. LOCATION Baltimore Md | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 28 1965 | | 25B. NAME OF REGISTRAR P. E. J. J. J. | | 25C. FUNERAL DIRECTOR Harry H. Amacost | |
| | | | | ADDRESS 4204 Ridgewood Dr. Balt. Md 21215 | |

12/15/52

JOHN A. MILLER

WADSWORTH

BAVARIAN

3030 BAVARIAN AVE

12/18/52

WADSWORTH

101A 30TH

MISS GRACE KOSCHER

WADSWORTH

WADSWORTH

DIABETES MEDICINE

NO

12/15/52

12/18/52

12/15/52

12/15/52

JOHN A. MILLER

JOHN A. MILLER

WADSWORTH

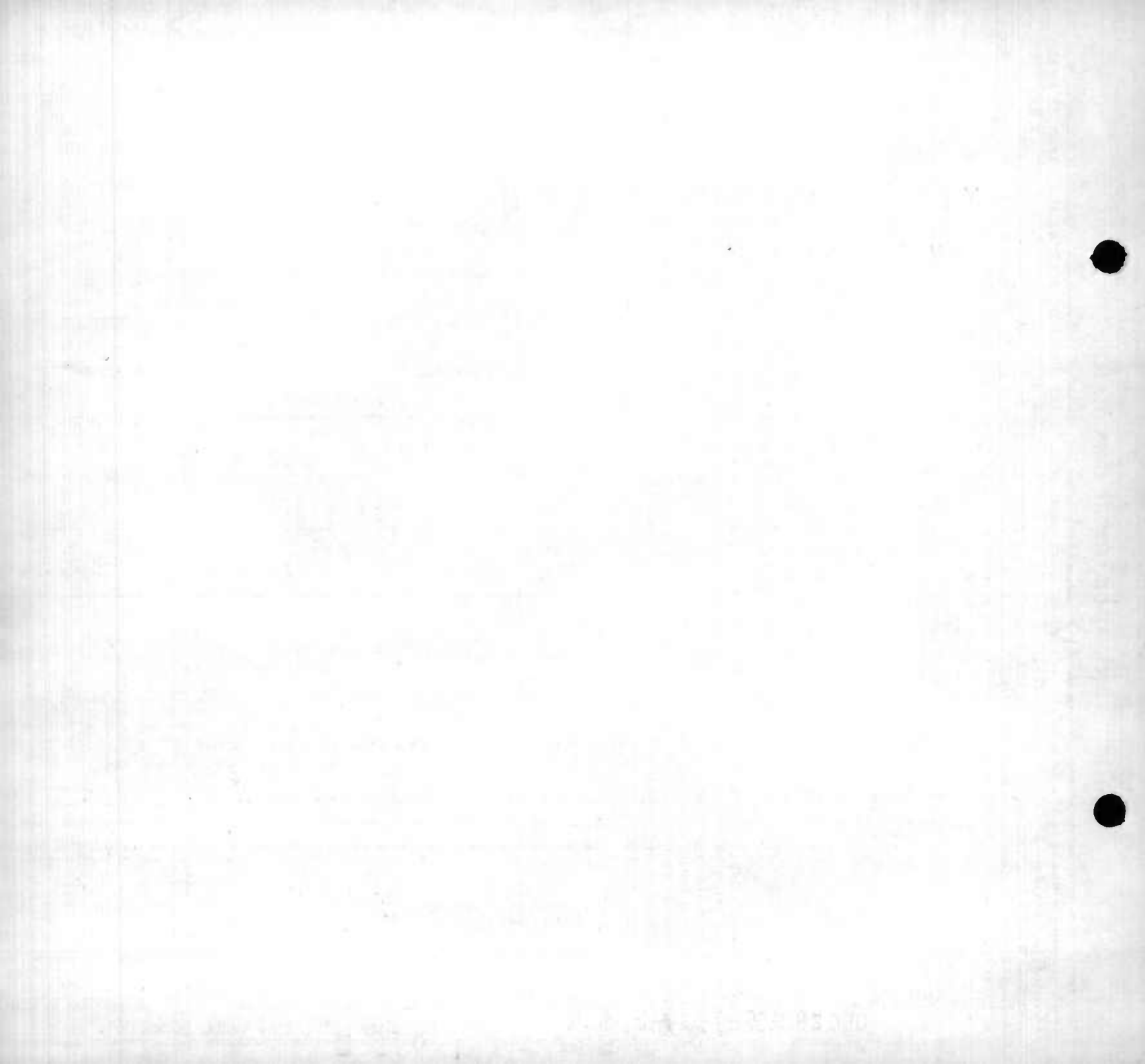
WADSWORTH

JOHN A. MILLER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

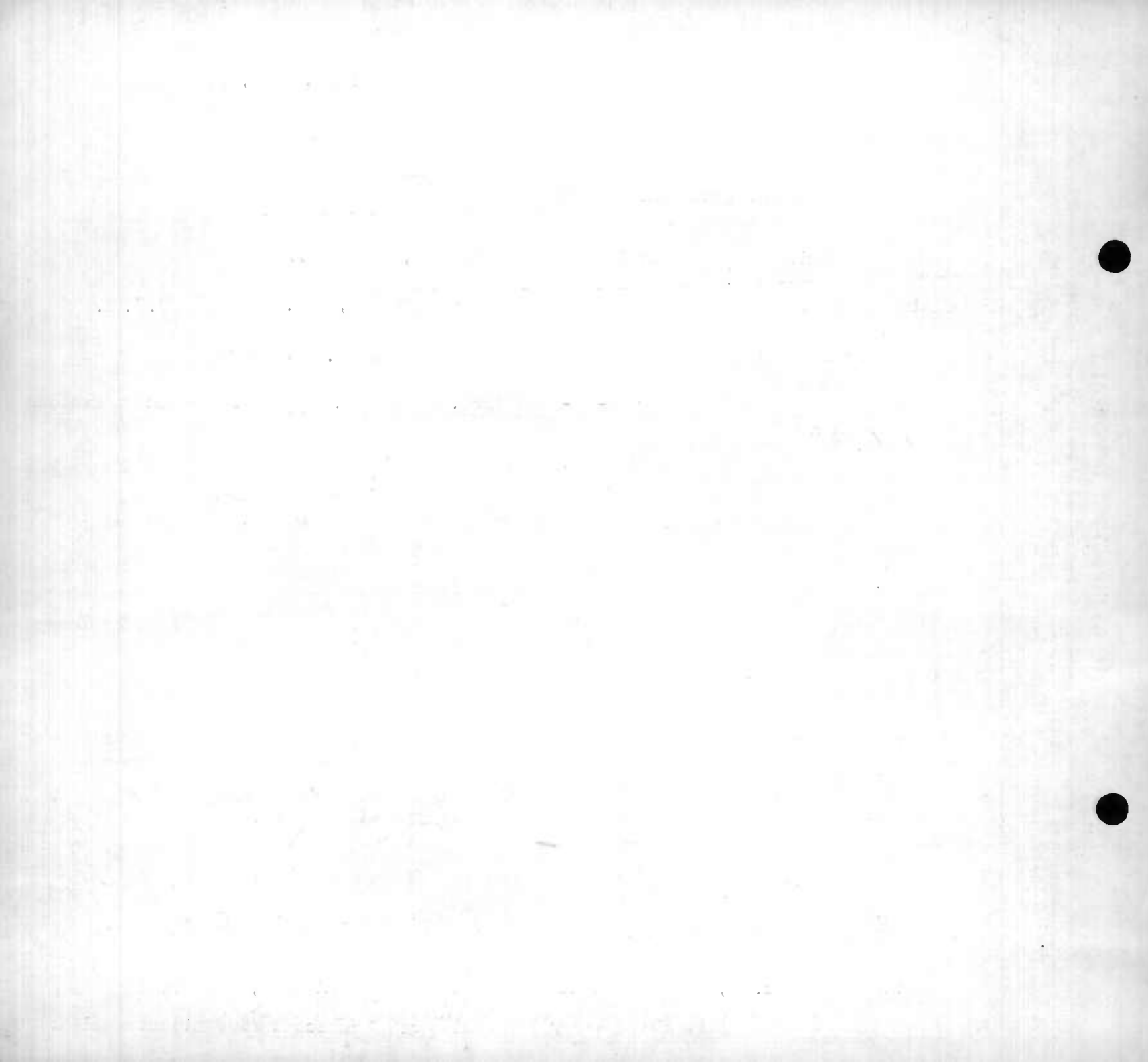
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13303 | |
|---|------------------|---|--|--|--|
| BIRTH NO. 65 13303 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) KATHERINE SHANEY | | | 2. DATE AND HOUR OF DEATH 12-23-65 3:15 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2205 CASTLE ST D. STREET ADDRESS (If rural, give location) BOLTON HILL NURSING HOME - LAFAYETTE - JOHN S. | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 5-19-82 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME GEORGE C. MUENCH | | | 14. MOTHER'S MAIDEN NAME KATHERINE OHEIM | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS NORMAN SHANEY 1912 WILHELM AVE, BALTO | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERSTINAL OBSTRUCTION (A) DUE TO STRANGULATED VENTRAL HERNIA (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 HRS | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 22 1965 to DECEMBER 23 1965, that (I) (we) lost saw the deceased alive on DECEMBER 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Rosario D. Bello</i> | | | | 23B. DATE SIGNED 12-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) ROSARIO D. BELLO | | | 23D. ADDRESS M.D. MARYLAND GEN. HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12-27-65 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore County, Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home, Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13304 | |
|---|----------------------------|--|---|--|--|
| BIRTH NO. 65 13304 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>George B. Appel</i> | | 2. DATE AND HOUR OF DEATH December 24, 1965 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 4300 Wentworth Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) 4300 Wentworth Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH July 18, 1898 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claims Adjustor | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Bernard Appel | | | 14. MOTHER'S MAIDEN NAME Annie M. Anderson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1 | | 16. SOCIAL SECURITY NO. 215-10-1351 | | 17. INFORMANT ADDRESS Mrs. Norma E. Appel 4300 Wentworth Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1 CAUSE OF DEATH (A) <i>Cerebral Vascular Hemorrhage</i> DUE TO (B) <i>Hypertensive Heart Disease</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i> <i>10 yrs.</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Paraplegia with Transverse Myelitis</i> | | | | <i>- 1953</i> | |
| 19A. DATE OF OPERATION <i>None</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb 6</i> 19 <i>44</i> to <i>Dec 24</i> 19 <i>65</i> ; that (I) (we) last saw the deceased alive on <i>Dec 23</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Earl L. Chambers M.D.</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <i>12/24/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Earl L. Chambers - 1</i> | | 23D. ADDRESS <i>4108 Liberty St - Balto - Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE Dec. 27, 1965 | 24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR <i>Ellsworth Armacost</i> ADDRESS 4600 Liberty Heights | |



1
C. 625

65 13305

BALTIMORE CITY HEALTH DEPARTMENT

65 13305

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|--|--|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) FRANK M. CROSSMAN | | | | 2. DATE AND HOUR PRONOUNCED DEAD December 27, 1965 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3922 Ridgewood XXXX Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-10 D. STREET ADDRESS (If rural, give location) 3922 Ridgewood XXXX Avenue | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Feb. 26, 1875 | | 9. AGE (In years last birthday) 90 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Structural Draftsman | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Phoenixville, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME William H. Crossman | | | | 14. MOTHER'S MAIDEN NAME Elizaberth Dunbar | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | | 16. SOCIAL SECURITY NO. Spanish-American | 17. INFORMANT ADDRESS Francis Crossman 3922 Ridgewood Avenue | | | |
| 18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Intestinal obstruction due to left inguinal hernia. | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ii OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED | | | |
| SIGNATURE <i>Russell S. Fisher</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 12-27-65 | | | |
| NAME (Type) Russell S. Fisher, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 12/31/65 | | 23C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 24B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | 24C. FUNERAL DIRECTOR ADDRESS <i>Ellsworth Armacost</i> Ellsworth Armacost 4600 Liberty Heights | | | |

1 7 6 5 0 0 1 1 2 1 5

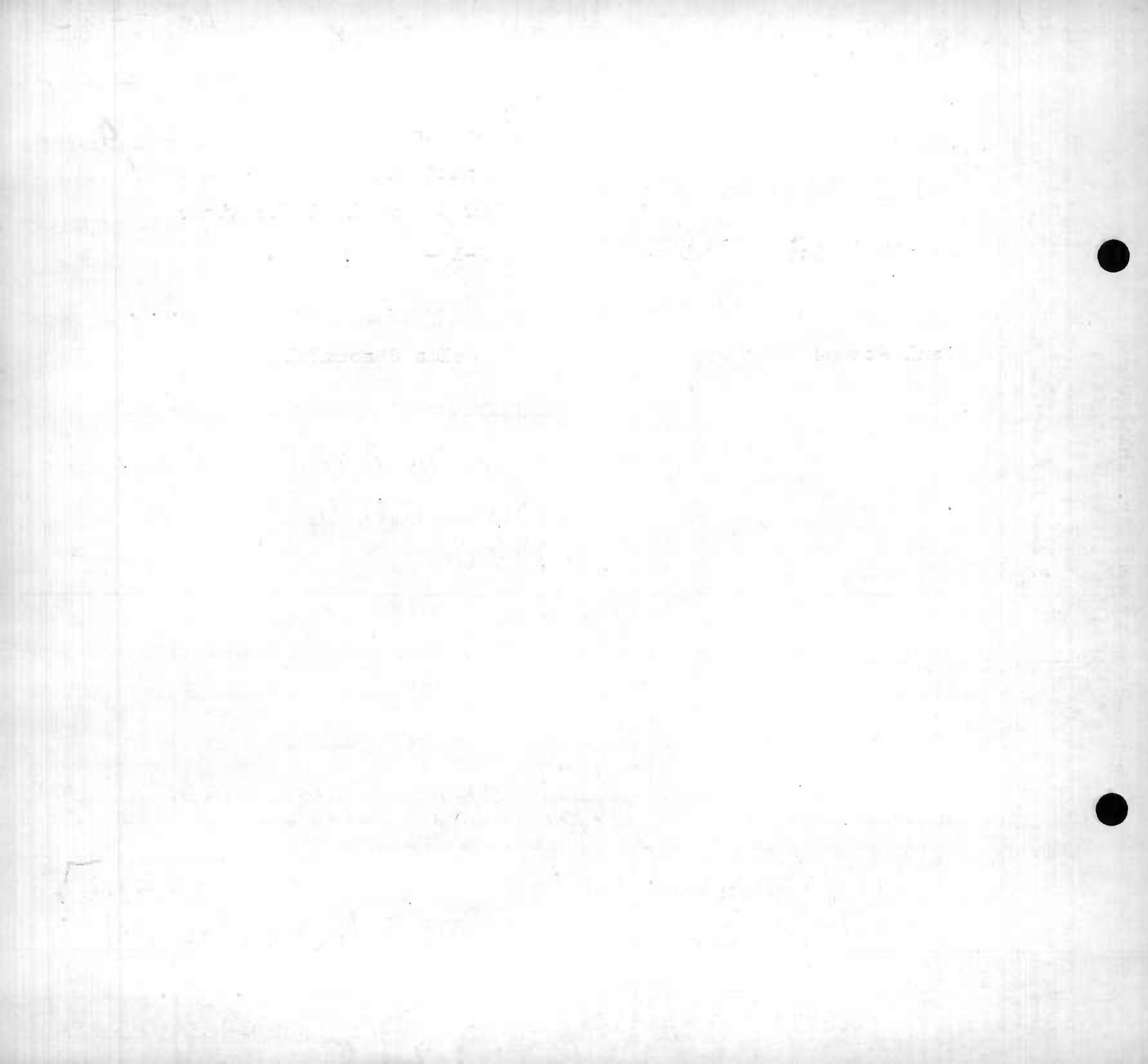
VALLEY FORCE

RECEIVED

Valley Force

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 65 13306 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 118 4253 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH X | | 65 13306 | |
| 1. NAME OF DECEASED (Type or Print) <u>Stumpf, Frieda</u> | | 2. DATE AND HOUR OF DEATH <u>12/27/65</u> <u>3:30</u> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Johns Hopkins Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balt</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>RT 6 Box 81 Middle River</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Widow</u> | 8. DATE OF BIRTH <u>5-10-00</u> | 9. AGE (In years last birthday) <u>65</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Paul Stumpf Fischer</u> | | 14. MOTHER'S MAIDEN NAME <u>Selma Shaoemfeld</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-46-1155</u> | | 17. INFORMANT <u>Mr Carl Stumpf 9750 Bird River Road</u> | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Caudate Arter</u> DUE TO (B) <u>Myocardial infarction</u> DUE TO (C) <u>ASCVD</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10-20 min.</u> <u>1 hour</u> <u>—</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>12/27</u> <u>1965</u> to <u>12/26</u> <u>1965</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>12/27</u> <u>1965</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>W. H. Spencer</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/27/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>W. H. SPENCER</u> | | 23D. ADDRESS <u>Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-27-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Zion Cemetery</u> | |
| 24D. LOCATION <u>Baltimore Co.</u> | | 24E. STATE <u>Md.</u> | | 24F. ADDRESS <u>36</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR <u>Lanahan Funeral Home 2401 Belair Road</u> | |



FUNERAL DIRECTOR: IMPORTANT

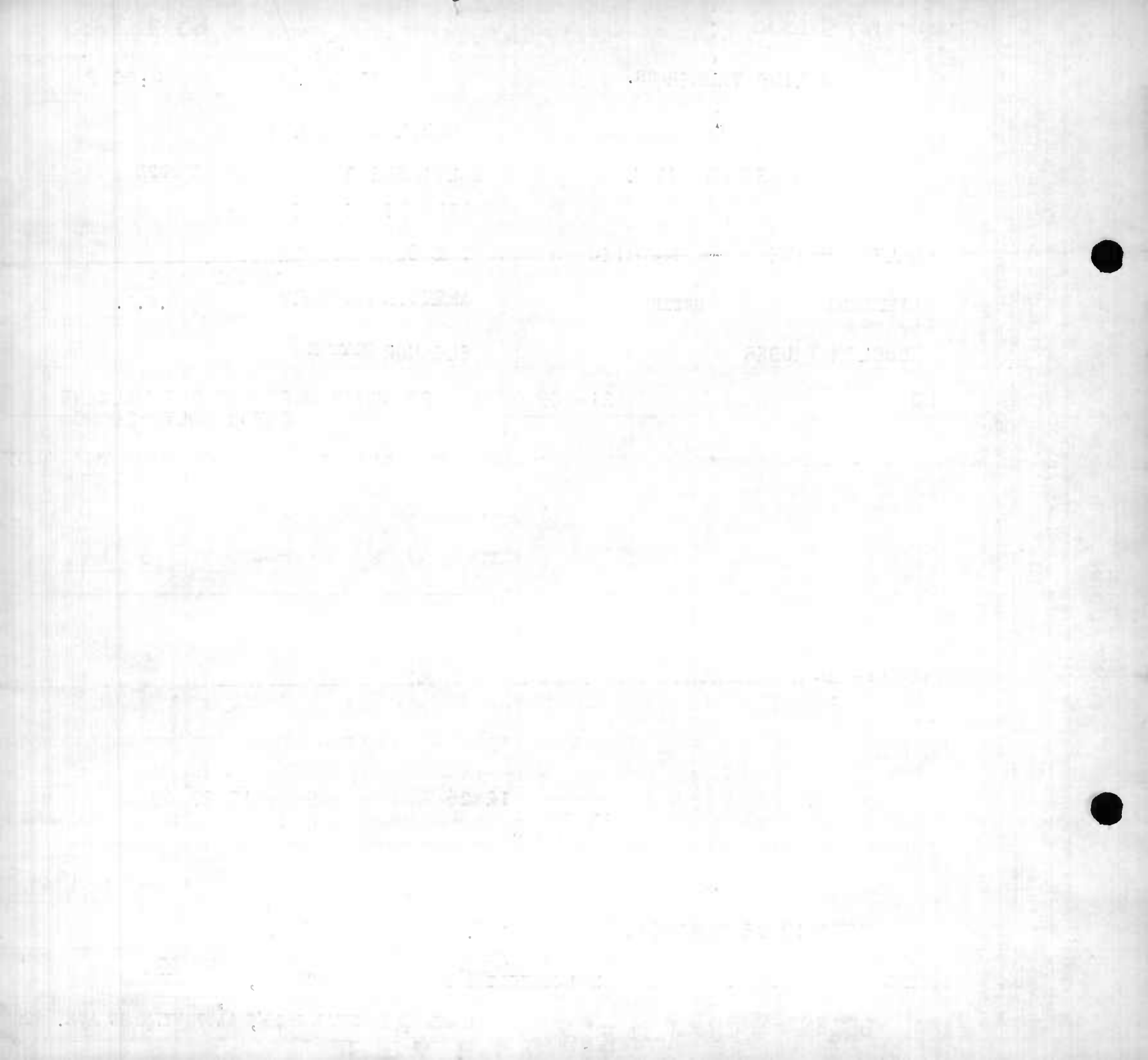
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13307 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13307 | |
|--|------------------|---|------------------------------|---|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Morris C. Chenowith | | | | 2. DATE AND HOUR OF DEATH 12-25-1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) John's Hopkins | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY Baltimore Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If rural, give location) Box 981 Lorely Beach Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-2-1907 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal | | 10B. KIND OF BUSINESS OR INDUSTRY Silver Top Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John T. Chenowith | | | | 14. MOTHER'S MAIDEN NAME Lula France | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705-10-8815 | | 17. INFORMANT Mrs Ethel E. Chenowith White Marsh | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) DUE TO Coronary Thrombosis | | | |
| | | | | (B) DUE TO Arteriosclerotic Heart Disease | | | |
| | | | | (C) DUE TO Pulmonary emphysema, Asthma. | | | |
| | | | | Diabetes mellitus. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 1960 to May 1965, that (I) (we) last saw the deceased alive on May 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Samuel Stern | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) Samuel Stern | | | | 23D. ADDRESS Ridge Rd, Baltimore 6, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-29-1965 | | 24C. NAME of CEMETERY or CREMATORY Belair Memorial Cemetery | | 24D. LOCATION (City, town, or county) (State) Belair, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.A. | | 25C. FUNERAL DIRECTOR Lassahn Funeral Home | | ADDRESS (36) 740 Belair Road | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|---|--|---|---|--|--|
| BIRTH NO. 65 13308 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13308 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JULIUS TAUBER SR. | | | | 2. DATE AND HOUR OF DEATH 12 27 65 4:00 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27 HALETHORPE 53-00 D. STREET ADDRESS (If rural, give location) 4337 RIDGE AVE 21227 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7 2 88 | 9. AGE (In years lost birthday) 77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | |
| 10B. KIND OF BUSINESS OR INDUSTRY RETIRED | | | 11. BIRTHPLACE (State or foreign country) AUSTRIA HUNGARY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME RUDOLPH TAUBER | | | | 14. MOTHER'S MAIDEN NAME ELEANOR HETTEL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216 09 4075 | | 17. INFORMANT ST AGNES HOSP RECORDS WILKENS & CATON BALTO 29 MD | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 154X I Metastatic Adeno Carcinoma rectum ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ADENOCARCINOMA OF RECTUM Intestinal obstruction | | | | INTERVAL BETWEEN ONSET AND DEATH over one year over one year 3 days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 12-22-1964 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (IX) (this hospital) attended the deceased from 12 26 1965 to 12 27 65 19, that (X) (we) lost saw the deceased alive on 12 27 65 19 and that (XXX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE OCTAVIO DE MARCHENA | | | | 23B. DATE SIGNED 12-27-1965 | | 23C. PHYSICIAN'S NAME (Type) OCTAVIO DE MARCHENA | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/30/65 | | 24C. NAME of CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL PARK | | 24D. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29 | | 25D. ADDRESS | |



W 236

65 13309

BALTIMORE CITY HEALTH DEPARTMENT

65 13309

BIRTH NO. 65-14135 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) MICHAEL T. WESTERFIELD 2. DATE AND HOUR PRONOUNCED DEAD
December 26, 1965 9:25 P. M.3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY BaltimoreFULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location) 4811 Eldon Green 21227

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) CHILD 8. DATE OF BIRTH JULY 6, 1965 9. AGE (In years last birthday) 5 10. MONTHS 20 11. HOURS 12. MIN.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD 10B. KIND OF BUSINESS OR INDUSTRY CHILD 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward F. Westerfield 14. MOTHER'S MAIDEN NAME Betty Ann JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. ----- 17. INFORMANT ADDRESS 21227
MR. EDWARD F. WESTERFIELD, 4811 ELDON GREEN

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Intestinal obstruction
DUE TO intussusception of terminal ileum and cecum into ascending colon.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

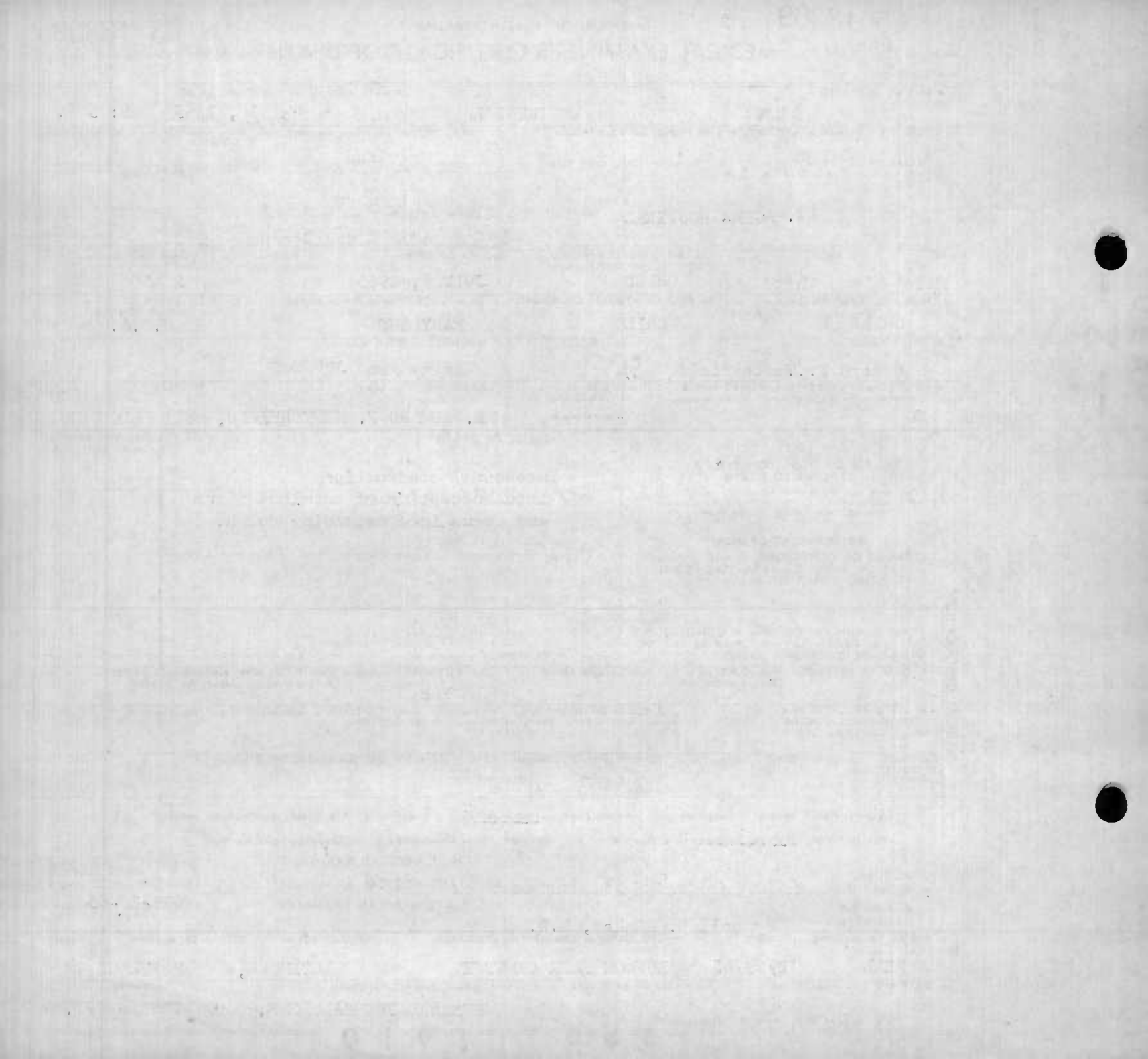
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 12-27-65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 12/29/65 23C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY 23D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND

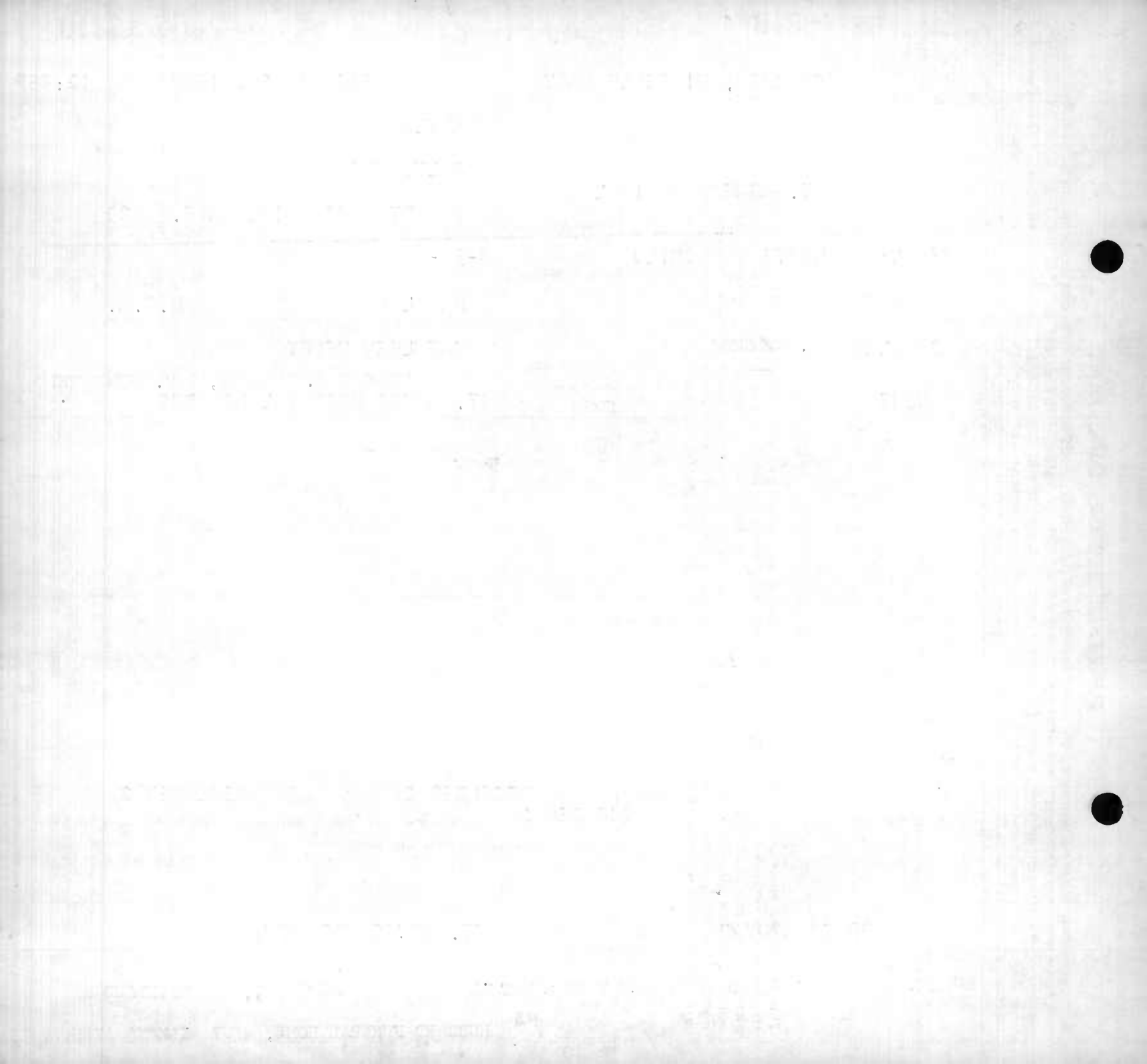
24A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. 24C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-------------------------|--|---|--|--|
| BIRTH NO. 65 13310 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13310 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CROCKEN, KIMBERLY MARY | | | 2. DATE AND HOUR OF DEATH DECEMBER 27, 1965 12:55P | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 7 NORTH BEECHFIELD AVE. #29 | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD | 8. DATE OF BIRTH 8-31-65 | 9. AGE (In years last birthday) 14 MO | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME CHARLES R. CROCKEN | | |
| 14. MOTHER'S MAIDEN NAME KATHLEEN HENRY | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE | | |
| 16. SOCIAL SECURITY NO. NONE | | | 17. INFORMANT CHARLES R. CROCKEN, 7 N. BEECHFIELD ST. AGNES HOSPITAL RECORDS AVE. # 29 | | |
| 18. 28-04-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) DUE TO Chyloper Storage Disease (B) DUE TO Coronary Heart Failure (C) _____ | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 27 19 65 to DECEMBER 27 19 65 , that (I) (we) last saw the deceased alive on DECEMBER 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Grace Ayuyao | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) GRACE AYUYAO | | | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 12/29/65 | | LOUDON PARK CEMETERY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 29 1965 | | Robert E. Taylor | | HUBBARD FUNERAL HOME, 4107 WILKENS AVENUE # 29 | |



1
D-400

65 13311

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13311

| | | | |
|--|---------|--|-------------------------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| Michael C. Dooley | | December 26, 1965 4:25 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | |
| ST. AGNES HOSPITAL | | B. COUNTY Baltimore | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | Baltimore Arbutus | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 1245 Circle Drive 21227 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH |
| Male | White | Married | 9/16/1914 |
| | | 9. AGE (In years last birthday) | 10. If Under 1 Yr. If Under 24 Hrs. |
| | | 51 | Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| SALES MANAGER | | KOPPERS | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| MICHAEL DOOLEY | | ANNIE CORCORAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| NO | | 212-09-8460 | |
| 17. INFORMANT | | ADDRESS | |
| MRS. MARGARET M. DOOLEY, 1245 CIRCLE DRIVE #27 | | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | |
| Arteriosclerotic cardiovascular disease | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | |
| | | | |
| (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 2 | | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Russell S. Fisher, M.D. | | DATE SIGNED | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| BURIAL | | 12/30/65 | |
| 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| NEW CATHEDRAL CEMETERY | | BALTIMORE, MARYLAND | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| DEC 29 1965 | | Robert E. Fisher, M.D. | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29 | | | |

19650011921

VALLEY
BANK
OF
AMERICA

K. 626

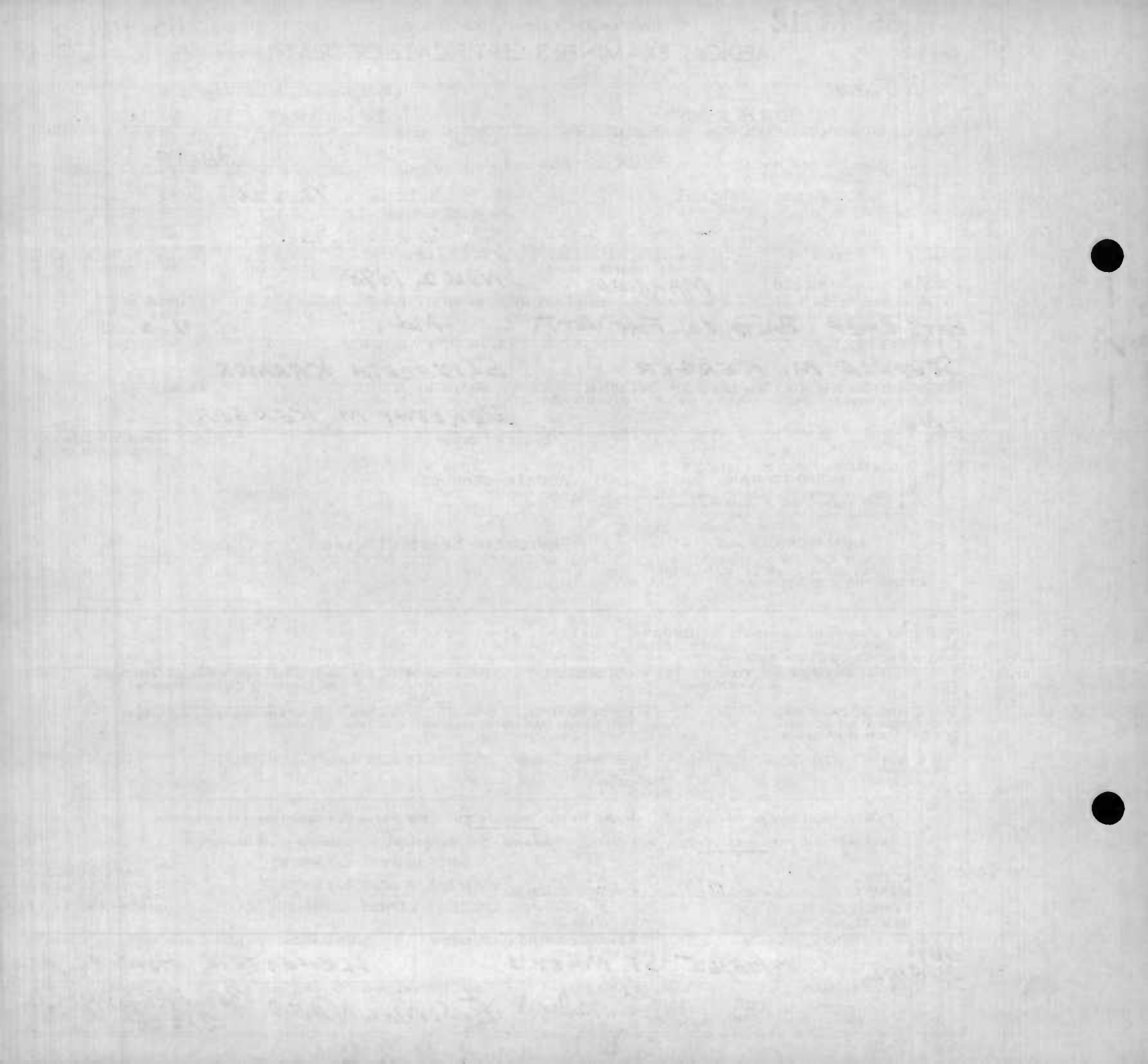
65 13312

BALTIMORE CITY HEALTH DEPARTMENT

65 13312

| | | | | | |
|---|---------|--|---|--|--|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| STEPHEN H. KERGER | | | 24 December 1965 1:25 p. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE Maryland B. COUNTY BALTO | | |
| St. Agnes Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Baltimore 21228 5300 | | |
| D. STREET ADDRESS (If rural, give location) | | | 15 Newberg Ave. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| male | white | MARRIED | NOV 2 1898 | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| BATT. CHIEF BALTO. CO. FIRE DEPT. | | | | Md. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| STEPHEN M. KERGER | | | ELIZABETH KRAMER | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| No | | | | | |
| 17. INFORMANT | | | ADDRESS | | |
| DOROTHY M. KERGER | | | | | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| Aortic stenosis | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| Rheumatic heart disease | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 12/25/65 | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 12/28/65 | | ST. MARK'S | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | |
| DEC 29 1965 | | Robert E. Farley M.D. | | E.S. MACNABB | |
| | | | | ADDRESS | |
| | | | | 361 FREDERICK RD 21228 | |

19650011922



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13313 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13313 | |
|--|---------------------|---|---|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) THOMAS J. TRENTLY | | | | 2. DATE AND HOUR OF DEATH 12/27/65 2:55 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND UNION M. HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 14-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION M. HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 132 W. LAFAYETTE AVE | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8/21/01 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD (BALTO MUSEUM OF ART) | | | 11. BIRTHPLACE (State or foreign country) PEWMA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME WILLIAM P. TRENTLY | | | | 14. MOTHER'S MAIDEN NAME BRIDGET O'HARA (D) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. JOHN M. TRENTLY SEVERNA PK, MD. | |
| 18. I 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Carcinoma of the Prostate, with metastasis (B) Prothrombinemia, bilateral (C) Pleural effusion, 700 cc. bilat. | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 12/5/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATE VISCUS | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/6 19 65 to 12/27 19 65 , that (I) (we) last saw the deceased alive on 12/27/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE VICTOR M. RODRIGUEZ, M.D. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) VICTOR M. RODRIGUEZ, M.D. | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/30/65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.A. | | 25C. FUNERAL DIRECTOR H.W. MEARS & SON | | ADDRESS 805 N. CALVERT ST. | |

JOHN H. B. HOUSE - 1111 N. CENTRAL ST. CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|------------------------------|---|---|--|---|
| BIRTH NO. 65 13314 | | CERTIFICATE OF DEATH | | Registered No. 65 13314 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) WIEGAND, LILLIAN MARY | | | 2. DATE AND HOUR OF DEATH 12-24-65 11:25P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) ZONE 29 218 S. AUGUSTA AVENUE | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 5-22-02 | 9. AGE (In years lost birthday) 63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY MD. WORKSHOP FOR THE BLIND. | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME FREDERICK WM. WIEGAND. | | | 14. MOTHER'S MAIDEN NAME CLEMENTINA BOGERSON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL--CATON & WILKENS | | |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) METASTASIS DUE TO (B) CD OF BREAST DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 65 13315 | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 15 1965 to DECEMBER 24 1965 , that (I) (we) last saw the deceased alive on DECEMBER 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Manfred F. Amrhein</i> | | | | 23B. DATE SIGNED 12/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) MANFRED F. AMRHEIN | | | 23D. ADDRESS M.D. CATON & WILKENS AVES. - BALTO. #29, MD. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12-27-65 | 24C. NAME of CEMETERY or CREMATORY MT. OLIVET CEM. | | 24D. LOCATION (City, town, or county) (State) BALTO., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Barth Miller 2334 Jeffers st.</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13315 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13315 | |
|--|---------------------|---|---|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) GERTRUDE MARIE WOLF | | | | 2. DATE AND HOUR OF DEATH DECEMBER 26 1965 3:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 603 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 418 N. BRADFORD ST. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH JUNE 4, 1900 | 9. AGE (In years lost birthday) 65 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 13. FATHER'S NAME PETER BERNHARDT | | | 14. MOTHER'S MAIDEN NAME MARY SE ROUSEK | | | ADDRESS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Virginia M. Holton - 418 N. Bradford St. | | | |
| 18. 6000 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) UREMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC PYELONEPHRITIS HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | INTERVAL BETWEEN ONSET AND DEATH MONTH YEAR YEARS | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 19 1965 to December 26 1965 , that (I) (we) last saw the deceased alive on December 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ephraim B. Barzaga M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-26-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) EPHRAIM BARZAGA M.D. | | | | 23D. ADDRESS CHURCH HOME & HOSPITAL - BALTO. 31, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-30-65 | | 24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER Cem. | | 24D. LOCATION (City, town, or county) (State) BALTO. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Taylor & Miller | | ADDRESS 2334 Jefferson St. | |

CHURCH MEMBERS LIST

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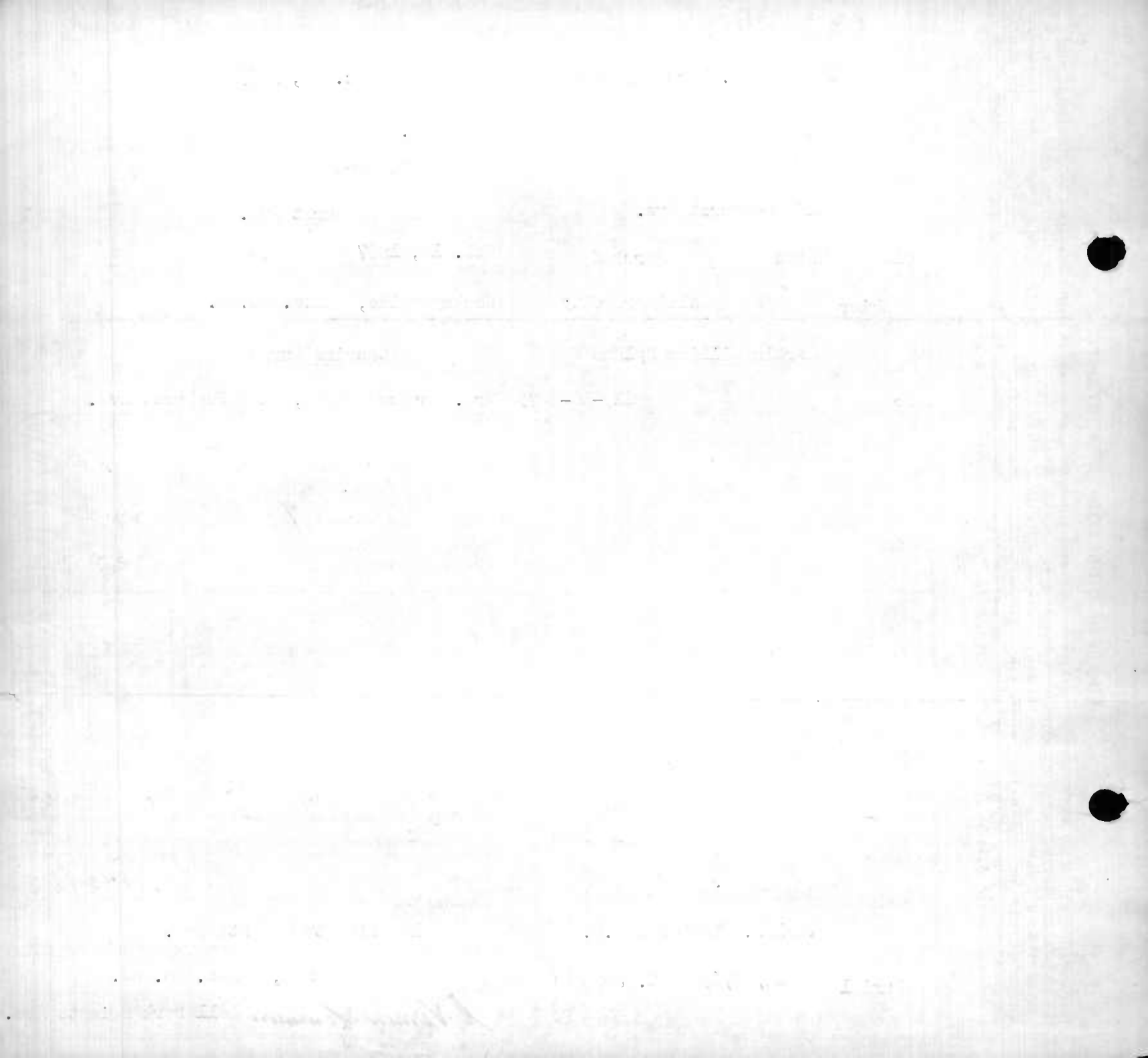
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 13316</u> | |
|---|-------------------------|--|--|--|--|---|--|
| BIRTH NO. <u>65 13316</u> | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>M. Burns Hyland</u> | | | | 2. DATE AND HOUR OF DEATH <u>Dec. 26, 1965</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Md.</u> | | B. COUNTY <u>15-10</u> | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | D. STREET ADDRESS (If rural, give location) <u>4108 Penhurst Ave.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>Feb. 14, 1887</u> | 9. AGE (In years last birthday) <u>78</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Balto. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Martin William Hyland</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katherine Burns</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-10-0875</u> | | 17. INFORMANT ADDRESS <u>Mrs. Louise Hyland, 4108 Penhurst Ave.</u> | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO <u>Arterio Sclerotic Heart Disease</u> | | <u>- 10 yrs.</u> | |
| ANTECEDENT CAUSES | | | | (B) DUE TO <u>Chronic Glomerular Nephritis</u> | | <u>- 5 yrs.</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) <u>Bronchectasis</u> | | <u>5 yrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <u>Emphysema</u> | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 24, 1961</u> to <u>Dec. 26, 1965</u> , that (I) was lost saw the deceased alive on <u>Dec. 22, 1965</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Earl L. Chambers</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12/28/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers, M.D.</u> | | | | 23D. ADDRESS <u>4108 Liberty Heights Ave.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/29/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Joseph's Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Texas, Balto. Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>B. Vernon Lemmon</u> | | ADDRESS <u>4611 Park Heights Ave.</u> | |



65 13317

BALTIMORE CITY HEALTH DEPARTMENT

65 13317

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

JOHN MacMullen

2. DATE AND HOUR PRONOUNCED DEAD

December 26, 1965

2:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2719 Greenmount Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

337 E. 27th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

10/22/98

9. AGE (In years
last birthday)

74

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Brakeman

10B. KIND OF BUSINESS OR INDUSTRY

Rail Road

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walton MacMullen

14. MOTHER'S MAIDEN NAME

Lulu (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 1

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

337 E. 27th St

Peggy J. Hurley Baltimore, Md. 21211

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO aspiration of gastric contents

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute ethylism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

House

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

2719 Greenmount Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 25 65 11:00 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Aspirated gastric contents

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-27-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/29/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Catonsville, Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 29 1965

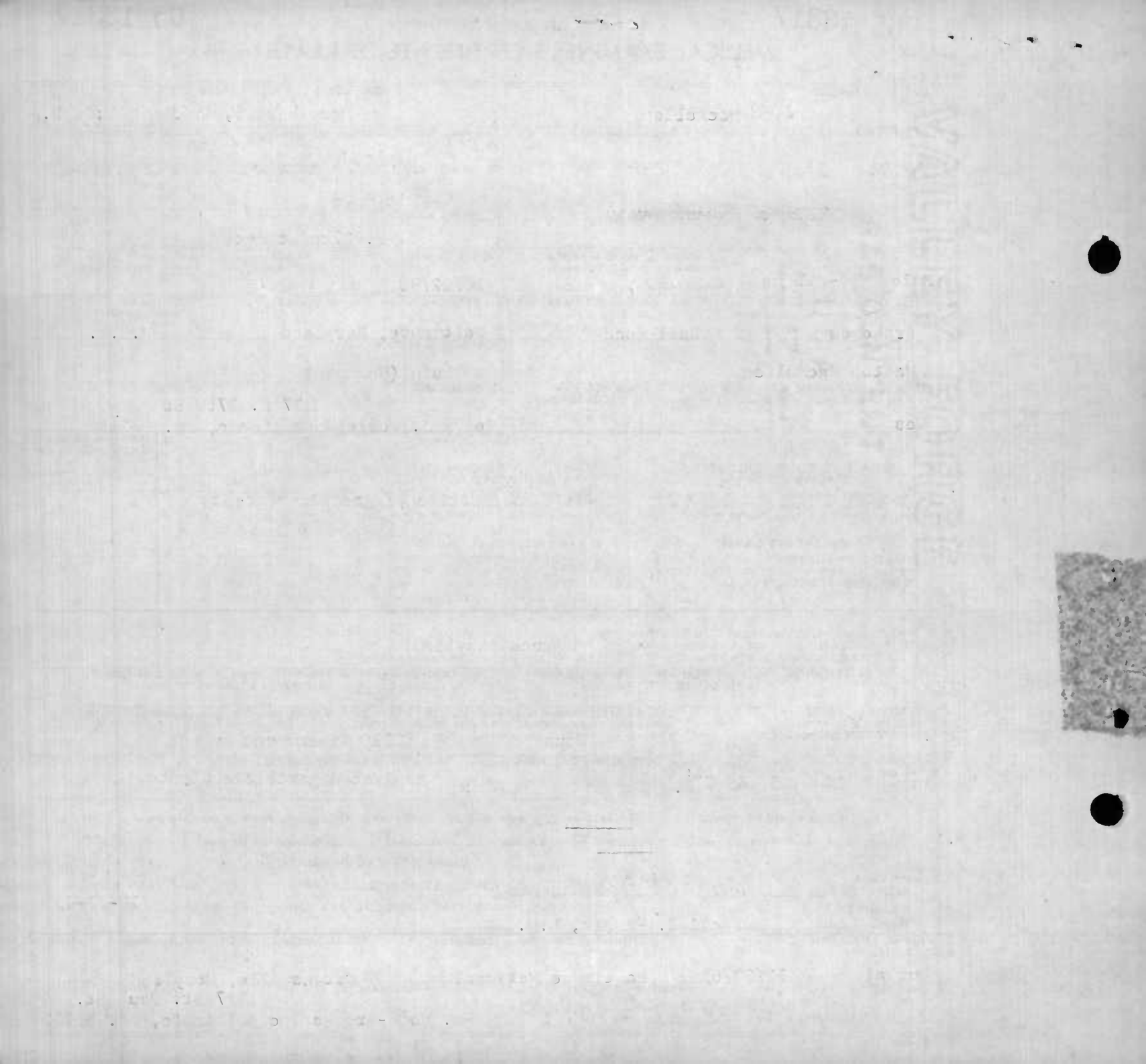
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc Baltimore, Md. 21202

1217 St. Paul St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|--|--|
| BIRTH NO. 65 13318 | | REGISTERED NO. 65 13318 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| Jenkins, Yale W. | | 12/25/65 3:00 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | |
| PROVIDENT HOSPITAL, INC. 1514 Division Street Baltimore, Maryland 21217 | | Maryland 15-02 | |
| 5. SEX | | 6. DATE OF BIRTH | |
| Male | | 3/10/1903 | |
| 7. RACE | | 9. AGE (In years last birthday) | |
| Negro | | 62 yrs. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| Barber | | Maryland | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| Barber Shop | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Charles Henry Jenkins | | Mariah Watson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | 216-05-9794-A | |
| 17. INFORMANT | | ADDRESS | |
| Thelma Camphor, 1115 Tiffany Ct., Balto., Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | |
| ANTECEDENT CAUSES | | G-i. Malignancy | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | |
| | | (C) DUE TO | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| II | | myocardial infarction congestive heart failure | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 0 | | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| No | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| Home | | | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| While At Work | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 12-21-1965 to 12-25-1965, that (1) (we) lost saw the deceased alive on 12-24-65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| [Signature] | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| H. RIGAUD | | PROVIDENT HOSPITAL, INC. | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE | |
| Burial | | 12/27/65 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Mt. Auburn | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| DEC 29 1965 | | Charles R. Law | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| Charles R. Law | | 902 Madison Ave. | |

FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

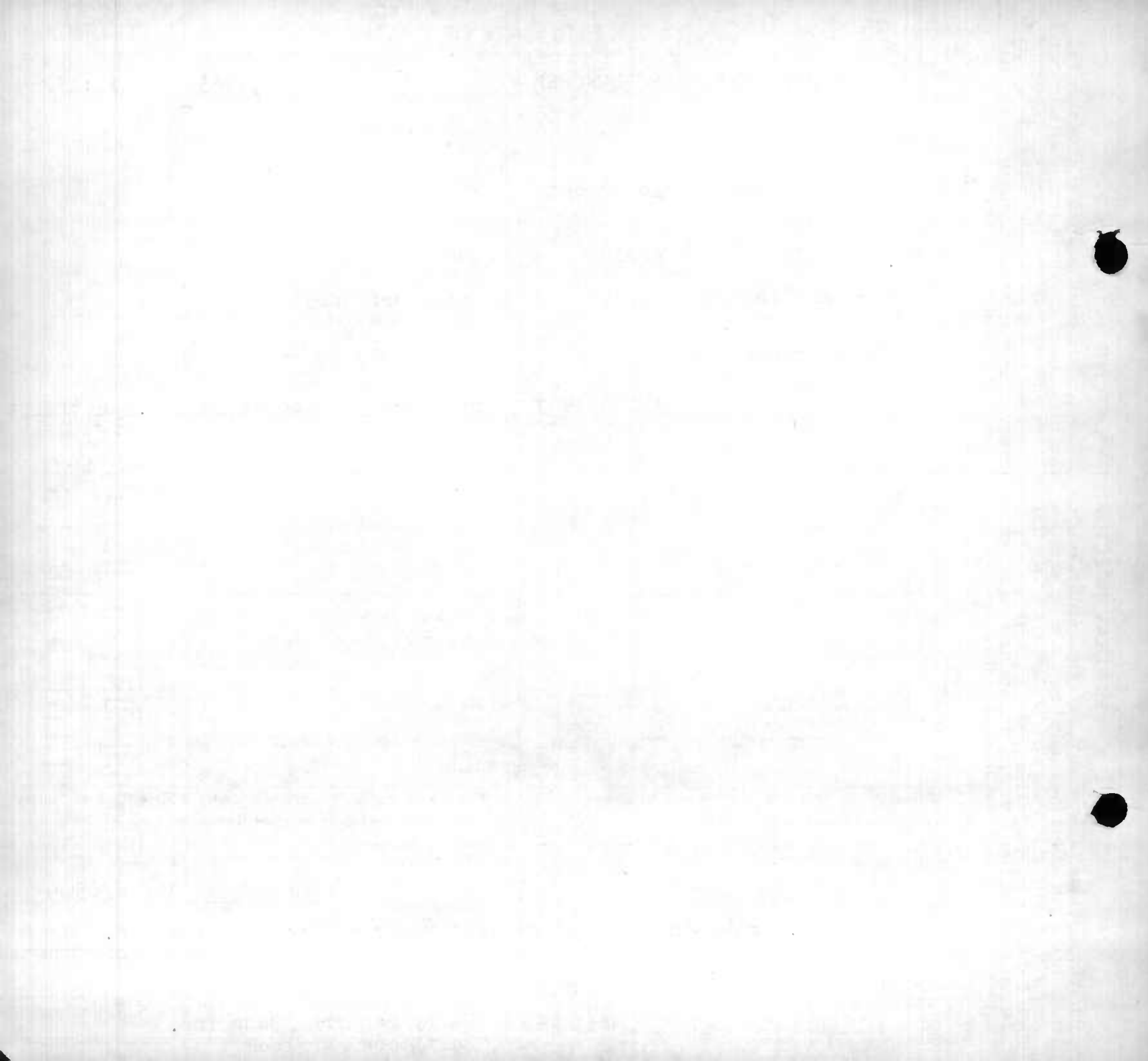
| | | | | | |
|---|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. 65 13319 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13319 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Hall, EDNA W. (EDNA W. HALL) | | 2. DATE AND HOUR OF DEATH 1965 12-26 10:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE U.S.A. B. COUNTY MD C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1115 East North Avenue D. STREET ADDRESS (If rural, give location) 2329 N. CHARLES ST. | | | |
| 5. SEX female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 12-18-92 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10B. KIND OF BUSINESS OR INDUSTRY at Home | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | 13. FATHER'S NAME John. E. Hall | | 14. MOTHER'S MAIDEN NAME KATIE HITCHCOCK ROBINSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Miss Helen R. Hall 1115 E. North Ave. | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. rt hemiplegia & cerebral vascular accident | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 12-26 10:30 PM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12-13 19 65 to 12-26 19 65 , that (I) (we) last saw the deceased alive on 12-26 10:30 PM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Pyong IL KWON | | 23B. DATE SIGNED 12/27/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) PYOUNG IL KWON | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/30/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Maryland | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Henry Sander & Sons Inc. Balto. Md | |
| 25C. FUNERAL DIRECTOR Henry Sander & Sons Inc. Balto. Md | | 25D. ADDRESS | | | |

BYRON L. LINDEN
THE NEW YORK PUBLIC LIBRARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---|---|--|
| BIRTH NO. 65 13320 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13320 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) FRANK CHARLES SCHUMACHER | | | 2. DATE AND HOUR OF DEATH DECEMBER 27, 1965 12:15P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1806 North Castle Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-05 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21213 | | |
| | | | D. STREET ADDRESS (If rural, give location) 1806 North Castle Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 17, 1889 | 9. AGE (In years last birthday) 76 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker Ward Bakery Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Casper Schumacher | | | 14. MOTHER'S MAIDEN NAME Henrietta Held | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 417 03 4903 | | 17. INFORMANT Mrs Clara Schumacher 1806 N. Castle St |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 154X + 260X Carcinoma of rectum with colostomy | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus Arteriosclerotic heart disease | | 7 years years |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/15/59 19 to 12/27/65 19, that (I) was lost saw the deceased alive on 12/24/65 19 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE  M.D. | | | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) M. Friedman | | | | 23D. ADDRESS M.D. 5211 Harford Road Baltimore Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn | |
| | | | | 24D. LOCATION (City, town, or county) (State) Woodlawn Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Sander | | 25C. FUNERAL DIRECTOR Henry Sander & Sons Inc. | |
| | | | | ADDRESS Baltimore Maryland | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 65 13321

| | | | |
|---|--|--|--|
| BIRTH NO. 65 13321 | | DATE AND HOUR OF DEATH 12-27-65 9:50 a.m. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John H. Grap | |
| 2. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| D. STREET ADDRESS (If rural, give location) 4205 Woodstock Avenue | | 5. SEX Male | |
| 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH 2-23-98 | | 9. AGE (In years last birthday) 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Grap | | 14. MOTHER'S MAIDEN NAME Sarah Vinton | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 214 01 9154 | |
| 17. INFORMANT Mrs Lillian E. Grap | | ADDRESS 4205 Woodstock Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atherosclerosis - chronic organ | | CAUSE OF DEATH (A) Staphylococcal septicaemia (B) Infected hip nail (C) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 weeks | |
| 19A. DATE OF OPERATION 12-1-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fr. hip | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOSPITAL | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 601 N. BROADWAY - OSLER #6 | | 21D. TIME OF INJURY (APPROX.) 11/28/65 | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? FALL TO FLOOR | |
| 22. I certify that (I) (this hospital) attended the deceased from October 28, 1965 to DECEMBER 27, 1965, that (I) (we) last saw the deceased alive on DECEMBER 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Nicholas J. Fortuin | | 23B. DATE SIGNED 12-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) Nicholas J. Fortuin | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/30/65 | |
| 24C. NAME OF CEMETERY or CREMATORY Baltimore | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | |
| 25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. | | ADDRESS BALTIMORE, MARYLAND | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13322 | |
|--|-------------------------|--|--|---|--|
| BIRTH NO. 65 13322 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Joseph or Giuseppe Di Blasi. | | 2. DATE AND HOUR OF DEATH 12/27-1965 10.30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2201 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 28 E. Henrietta St. | | D. STREET ADDRESS (If rural, give location) 28 E. Henrietta St. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH March 19-81 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Contractor | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Valguarnera-Italy | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Di Blasi | | 14. MOTHER'S MAIDEN NAME Stella Greco | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-16-3086 | | 17. INFORMANT ADDRESS Frances Di Blasi (Wife) 28 E. Henrietta St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 450.01 | | CAUSE OF DEATH (A) Uremia DUE TO (B) Generalized Atherosclerosis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from May 1 19 65 to Dec. 27 19 65 , that (1) (we) last saw the deceased alive on Dec. 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Vincent M. Messina M.D., M.D. | | | | 23B. DATE SIGNED 12-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) Vincent M. Messina | | 23D. ADDRESS M.D. 1403 S. Charles St Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 30/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md (6) | | 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR ADDRESS George Della Noce 322 S. High St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

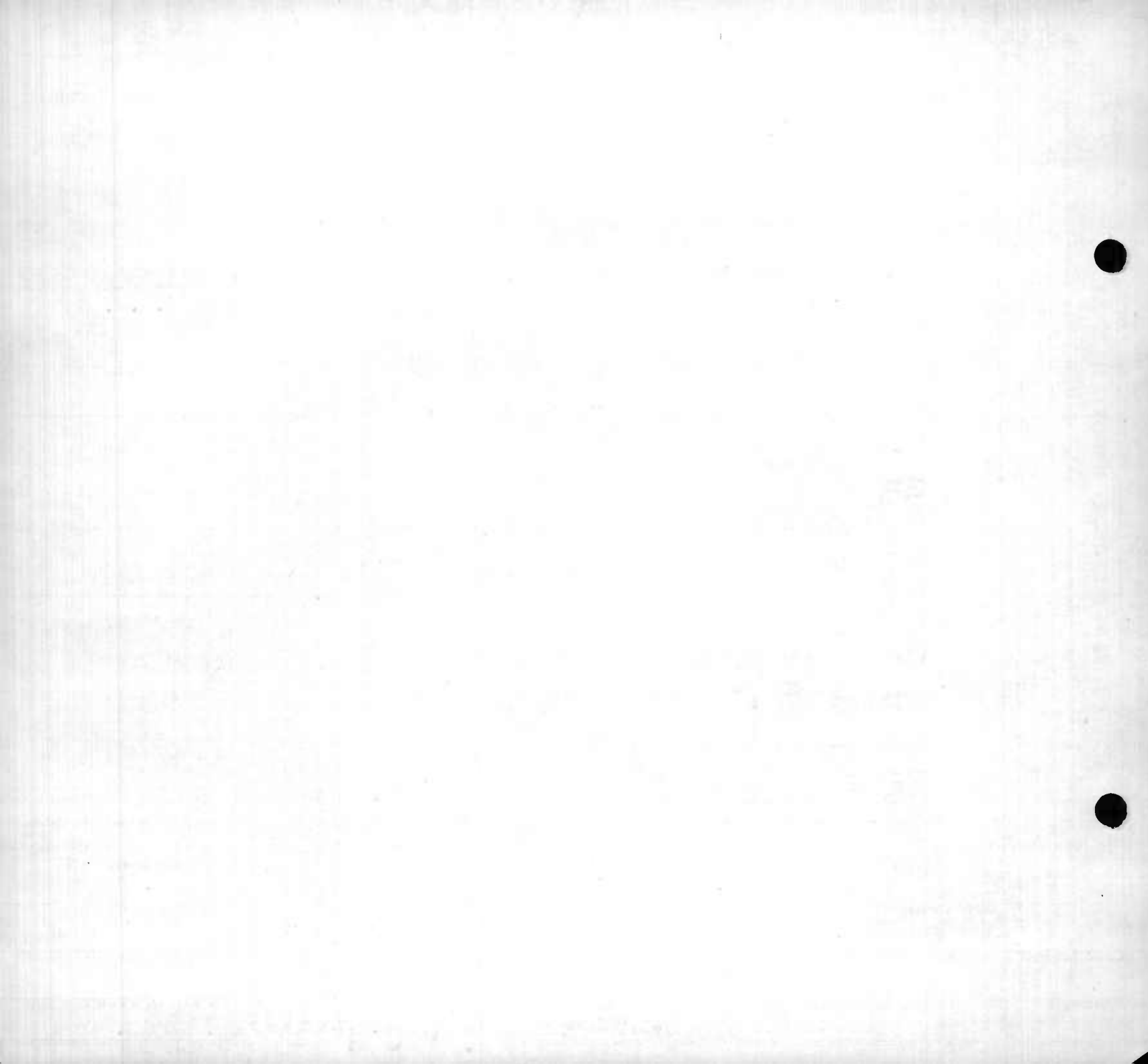
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|--|--|--|--|
| 65 13323 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13323 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| LOUISA GRACCHI | | 12-23-65 | | 3:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Church Home & Hosp. | | Md. Baltimore | | 27-34 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| F | | W | | Widowed | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. CITIZEN OF WHAT COUNTRY? | |
| 12-25-87 | | 78 | | USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| H-Wife | | | | Italy | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Unknown | | Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | Chart | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 199.2 | | Severe Anemia probably secondary to Carcinoma & Metastasis | | undeter. | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | undeter. | |
| | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Pneumonia | | hours | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 12-22-65 | | Tracheotomy | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-19-65 to 12-23-65, that (I) (we) last saw the deceased alive on 12-23-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Dr. A.E. Sabong, Jr. | | 12.13.65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. A.E. Sabong, Jr. | | Church Home & Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/27/65 | | Sacred Heart | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 29 1965 | | Robert E. Taylor | | Joseph Zanningo | |
| | | | | 263 | |

Joseph Darnice

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

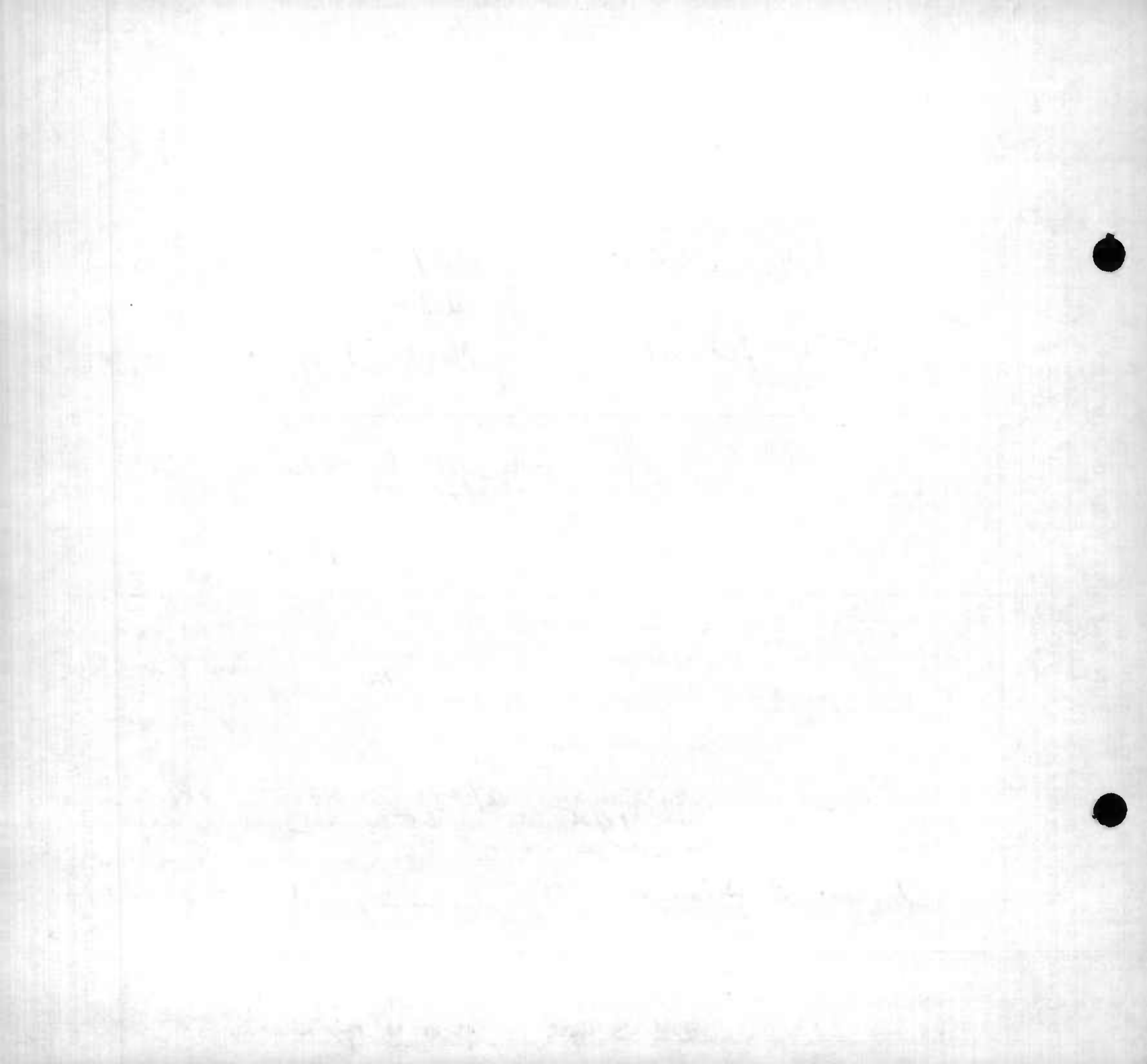
| | | | | | |
|--|------------------|--|--|--|--|
| BIRTH NO. 65 13324 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13324 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Evariste Tagliaferri | | | 2. DATE AND HOUR OF DEATH 12/22/65 9:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 3928 Claremont Street FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3928 Claremont St. | | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/15/1889 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) crane operator | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel | | 11. BIRTHPLACE (State or foreign country) Rome, Italy | |
| 13. FATHER'S NAME Loredo | | | 14. MOTHER'S MAIDEN NAME Justine Spaticiane | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-09-1081 | | 17. INFORMANT Mr. Loredo Tagliaferri | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 44-3X1 CAUSE OF DEATH Hypertension - Cardio-vascular disease INTERVAL BETWEEN ONSET AND DEATH | | | 19. DUE TO (A) _____ (B) _____ (C) _____ | | |
| 19. DUE TO (A) _____ (B) _____ (C) _____ | | | 20. DUE TO (A) _____ (B) _____ (C) _____ | | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1963 to 12/22 1965, that (I) (we) last saw the deceased alive on 12/21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph R. Liberto | | | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO | | | | 23D. ADDRESS 3508 BANK ST. BALTIMORE Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/27/65 | | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart | |
| 24D. LOCATION Baltimore, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Talbot | | 25C. FUNERAL DIRECTOR Joseph W. Zannino, Jr. 263 S. Conkl | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. <u>65-29869</u> <u>65</u> 13325 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. <u>65</u> 13325 | |
| 1. NAME OF DECEASED (Type or Print) <u>FRANCESCO SCANNELLO</u> | | | 2. DATE AND HOUR OF DEATH <u>12/25/65</u> <u>1 5⁴⁵</u> P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 MERCY HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>GLEN BURNIE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>GA</u> D. STREET ADDRESS (If rural, give location) <u>114 Vernon Ave.</u> <u>5200</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>11/30/65</u> | 9. AGE (In years last birthday) <u>25</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Mr. Patrick Scannello</u> | | | 14. MOTHER'S MAIDEN NAME <u>Marie Maggitti</u> (as above) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| 18. <u>340.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumococcal and staphylococcal meningitis</u> | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>27 hours approx.</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> 19 <u>65</u> to <u>12/25</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Emelda B. Salario</u> | | | | 23B. DATE SIGNED <u>12/25/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>M.D.</u> | | | | 23D. ADDRESS <u>M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/27/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Sacred Heart</u> | |
| 24D. LOCATION <u>Balto. Md.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1965</u> | | 24F. NAME OF REGISTRAR <u>Robert E. Fiala</u> | |
| 24G. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1965</u> | | 24H. NAME OF REGISTRAR <u>Robert E. Fiala</u> | | 24I. FUNERAL DIRECTOR <u>Joseph J. Bennett</u> | |
| 24J. ADDRESS <u>263 Glendy</u> | | | | | |



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0-350

65 13326

BALTIMORE CITY HEALTH DEPARTMENT

65 13326

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

| | | | |
|--|-------------------------|--|--|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) MARY ODEN | | 2. DATE AND HOUR PRONOUNCED DEAD December 26, 1965 7:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 202 East Read Street | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 202 E. Read Street | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Aug. 26, 1907m |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 9. AGE (in years last birthday) 58 |
| 11. BIRTHPLACE (State or foreign country) Salisbury, North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edgar B. Ennis | | 14. MOTHER'S MAIDEN NAME Emma Trexler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Salisbury Mrs. James Wilson 704 N Craig St. Maryland |
| 18. CAUSE OF DEATH 490X+322.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Lobar pneumonia DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic ethylism II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Partial |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 23B. DATE Dec. 27, 1965 | 23C. NAME of CEMETERY or CREMATORY Chestnut Hill Cemetery |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. | 24C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St. |
| 23D. LOCATION (City, town, or county) (State) Salisbury North Carolina | | | |

19650011936

WALTON COUNTY

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/10/01 BY 60322
JAN 10 2002

WALTON COUNTY
FLORIDA
JAN 10 2002

WALTON COUNTY
FLORIDA
JAN 10 2002

FUNERAL DIRECTOR: IMPORTANT

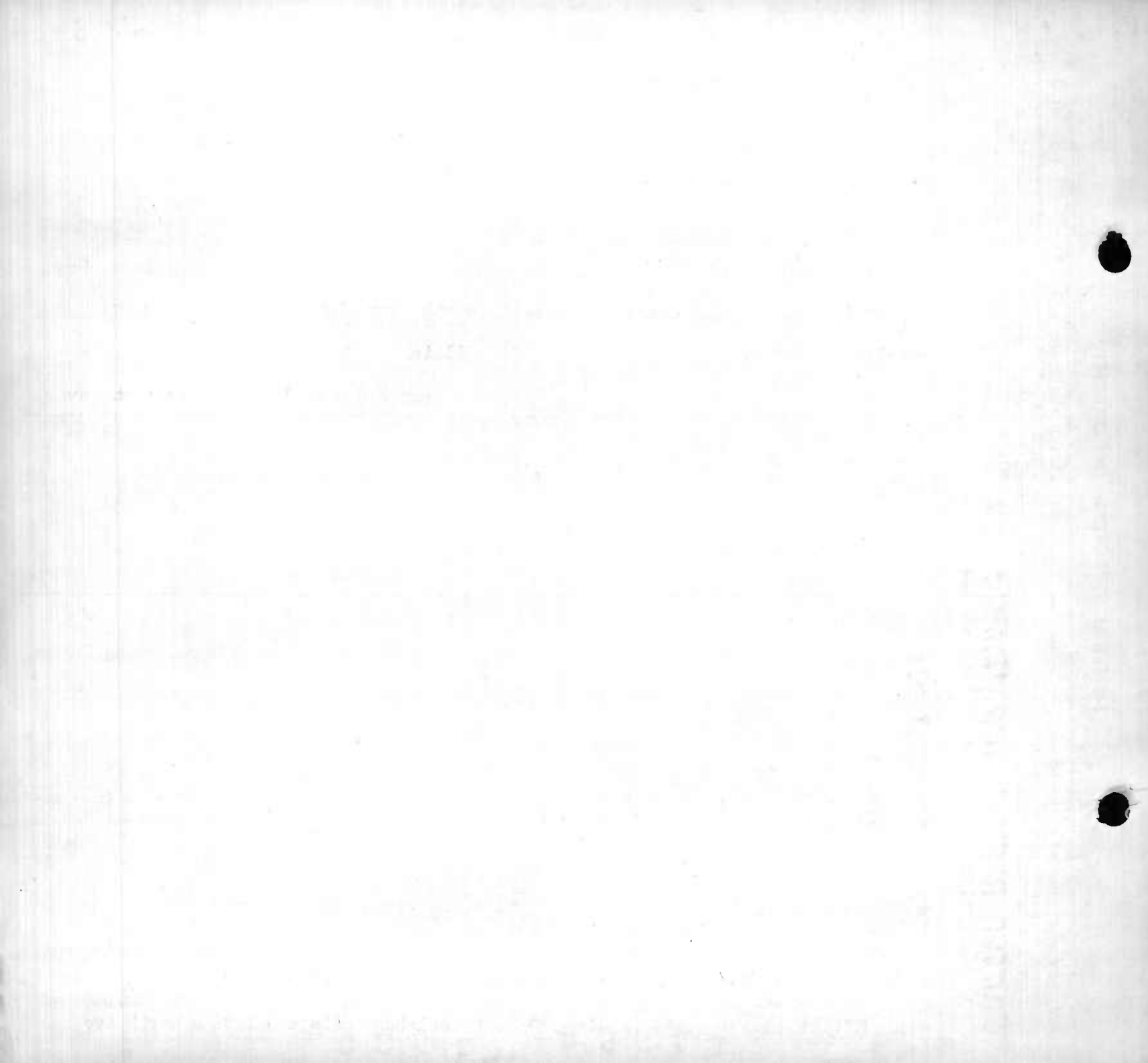
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 13327</u> | |
|--|---------------------|---|-----------------------------------|--|--|
| BIRTH NO. <u>65 13327</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>JOHN MCGEE</u> | | 2. DATE AND HOUR OF DEATH <u>DECEMBER 25, 1965</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>PROVIDENT HOSPITAL (D O A)</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>14-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 17,</u> D. STREET ADDRESS (If rural, give location) <u>513 Laurens St</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>DIVORCED</u> | B. DATE OF BIRTH <u>6/1/95</u> | 9. AGE (In years lost birthday) <u>70</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | 13. FATHER'S NAME | | | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>213-09-2004</u> | | 17. INFORMANT ADDRESS <u>Mrs Rose Mosley 513 Laurens St</u> | | | |
| 18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <u>pneumonia</u> (B) DUE TO <u>ASCD & coronary insufficiency</u> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>a few years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-5</u> 19 <u>64</u> to <u>12-25</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-25</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Hirositi Nakazawa</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>12-27-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HIROSHI NAKAZAWA</u> | | 23D. ADDRESS <u>521 W. Lexington St. Balto. 1. Ma</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/29/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u> | |
| 24D. LOCATION <u>Baltimore Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> | | | |
| 25D. ADDRESS <u>1206 W. North Ave</u> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

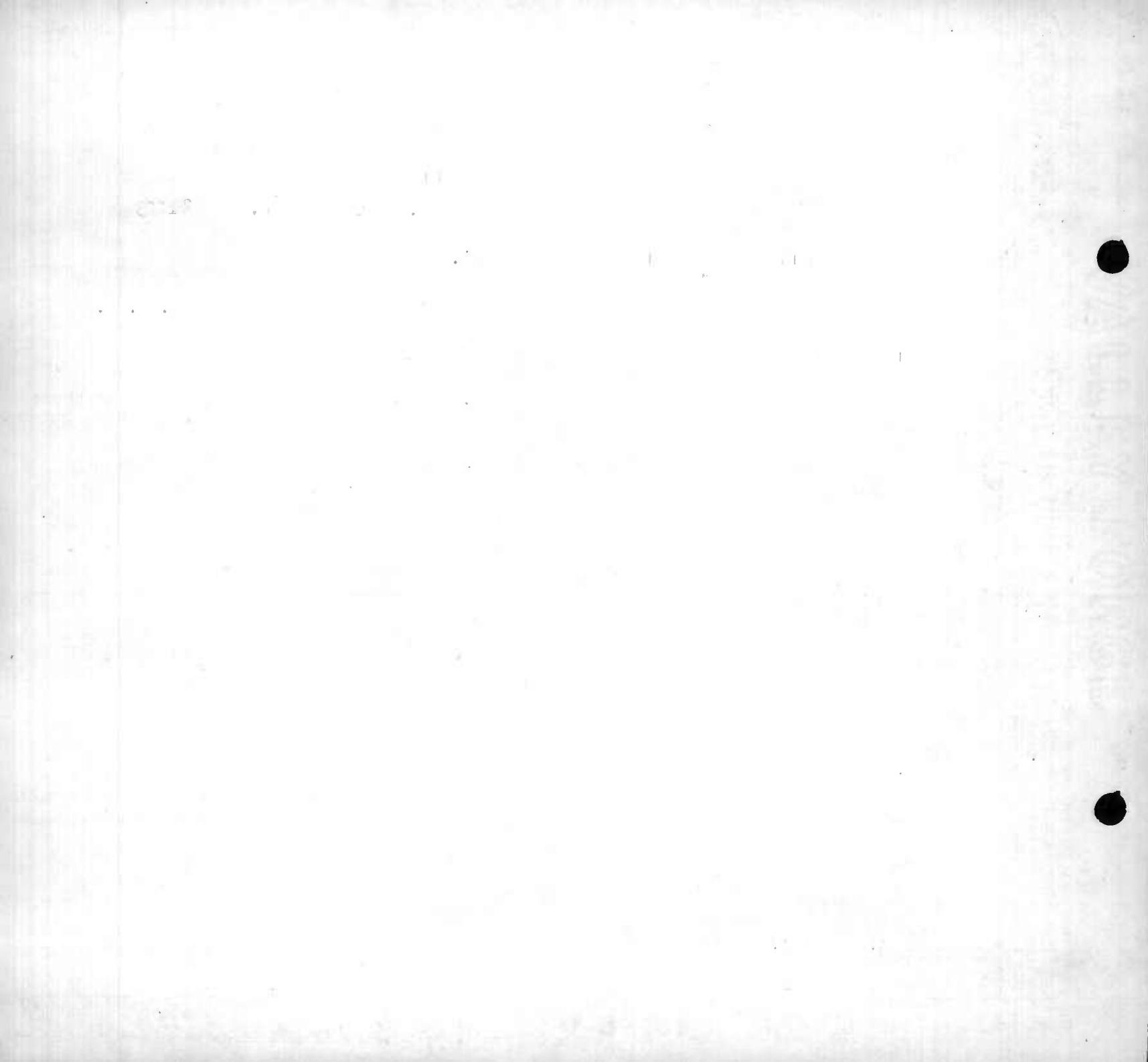
| | | | | | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 65 13328 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13328 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Pattie O'NEAL | | | 2. DATE AND HOUR OF DEATH 12-27-65 2:45 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSP. OF MD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 16-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2505 W. LAFAYETTE AVENUE. | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6/8/17 | 9. AGE (In years lost birthday) 48 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Charles Alston | | 14. MOTHER'S MAIDEN NAME Lillie | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr George W O Neal 2505 W Lafayette ave | |
| 18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Subarachnoid Hemorrhage DUE TO (B) Hypertension DUE TO (C) _____ | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 24 19 65 to DECEMBER 27 19 65 , that (I) (we) last saw the deceased alive on DECEMBER 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert C. Blackmon | | | | 23B. DATE SIGNED 12/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) Robert C. Blackmon | | | | 23D. ADDRESS Lutheran Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/29/65 | | 24C. NAME OF CEMETERY or CREMATORY National Cemetry | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Talley | | 25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

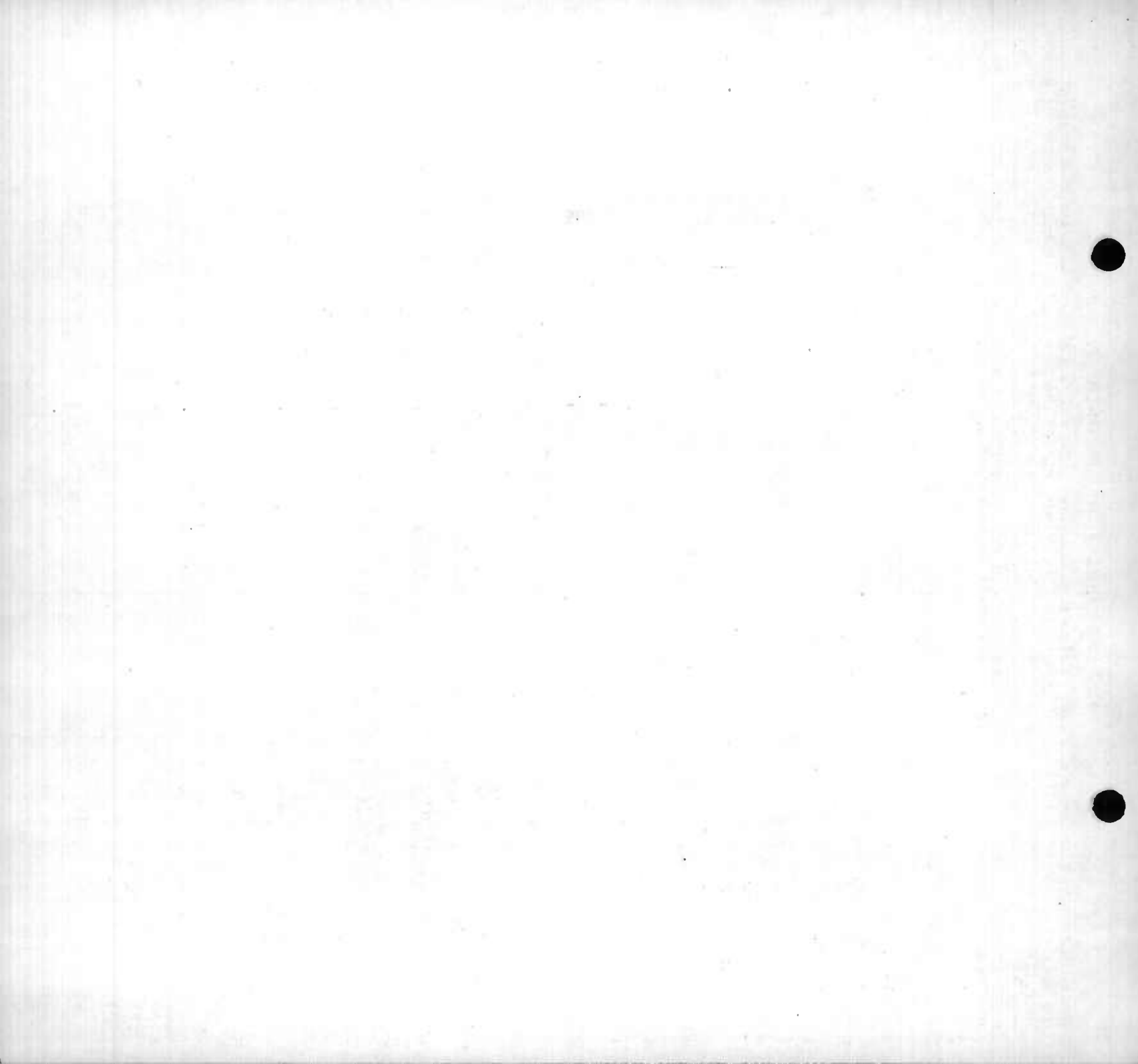
| | | | | | |
|---|-------------------------|---|--------------------------------------|---|---|
| BIRTH NO. 65 13329 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13329 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) JENNIE PAPPAS | | 2. DATE AND HOUR OF DEATH 12/26/65 7:40 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 19-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 234 S. CALHOUN ST. 21223 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH Oct. 1892 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Greece | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME LOUIS DEZES | | 14. MOTHER'S MAIDEN NAME STELLA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Chris Charelombou same address as above | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction | | CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardiovascular Disease (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH Wmins. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Congestive Heart failure | | 15 yrs. | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 12/15 1965 to 12/26 1965 , that (2) (we) last saw the deceased alive on 12/26 1965 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W.H. Spence III | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) W.H. SPENCE III | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/30/1965 | | 24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery | |
| 24D. LOCATION Woodlawn, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Stodolny | | 25C. FUNERAL DIRECTOR Wm. F. Jackson & Sons | | | |
| 25D. ADDRESS Baltimore, Md. 17 North & Pa. aves. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13330 | | REGISTERED NO. 65 13330 | |
|--|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Grace C. Tucker | | December 27, 1965 5 ²⁰ P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Maryland | | B. COUNTY Baltimore | |
| Wesley Home, Incorporated 2211 West Rogers Avenue Baltimore, Maryland 21209 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 27-15 | |
| D. STREET ADDRESS (If rural, give location) | | | | 2211 West Rogers Avenue | | 21209 | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH 5/12/1885 | |
| 9. AGE (In years lost birthday) 80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME George Cockman Tucker | | | | 14. MOTHER'S MAIDEN NAME Margaret Stultz | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 215-07-8243 | | 17. INFORMANT ADDRESS The Wesley Home, Inc. 2211 W. Rogers Ave. | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO Cerebral Vascular Accident | | 1 day | |
| (B) DUE TO Arteriosclerotic Cardio-vascular disease | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 23 August 1963 to 27 December 1965, that (I) (we) last saw the deceased alive on 27 December 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John W. Barnaby | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 28 Dec 65 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN W. BARNABY | | | | 23D. ADDRESS M.D. 1531 E. North Ave. Baltimore Md 21213 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/30/1965 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Wm. J. Fickner & Sons | | ADDRESS Baltimore, Md. 17 North & Pa. Ave. | |



T 520

65 13331

BALTIMORE CITY HEALTH DEPARTMENT

65 13331

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GEORGE TOWNES 2. DATE AND HOUR PRONOUNCED DEAD December 21, 1965 10:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

39 Provident Hospital D. STREET ADDRESS (If rural, give location) 1138 N. Carrollton Avenue

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH Oct 30 1913 9. AGE (In years last birthday) 52 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Greenville SC 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter TOWNES 14. MOTHER'S MAIDEN NAME Lottie Duggs 1138 Carrollton Ave

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ALLEN TOWNES 1138 n Carrollton Ave ADDRESS

18. 490X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia. DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO

(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty Liver and Cirrhosis.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 12/26/65 23C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery 23D. LOCATION (City, town, or county) (State) Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT. DEC 29 1965 24B. NAME OF REGISTRAR Robert E. ... 24C. FUNERAL DIRECTOR Joseph H. ... 24D. ADDRESS 2222 W. North Ave Baltimore, Md

VS 151-REV. 1/1/65 9650011941

WALLINGFORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 65 13332 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 13332 | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Maggie Savage</i> | | | | | 2. DATE AND HOUR OF DEATH <i>12-23-65 6:30 P. M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp.</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give town name) <i>Baltimore</i> | | | | |
| D. STREET ADDRESS (If rural, give location) <i>3001 Cherryland Rd</i> | | | | | 5. SEX <i>F</i> | | | | |
| 6. RACE <i>Negro</i> | | | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | | | | |
| 8. DATE OF BIRTH <i>6-22-43</i> | | | | | 9. AGE (In years lost birthday) <i>43</i> | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | 13. FATHER'S NAME <i>John Demmer</i> | | | | |
| 14. MOTHER'S MAIDEN NAME <i>Martha Hopkins</i> | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | |
| 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT <i>Charles Savage 3001 Cherryland Rd</i> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) <i>Intracerebral hemorrhage</i> DUE TO (B) <i>Hypertensive arteriosclerotic cardiovascular disease</i> DUE TO (C) <i>Diabetes mellitus</i> | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>8-9 hours</i> | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) <i>YES</i> | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that the (this hospital) attended the deceased from <i>12-23 1965</i> to <i>12-23 1965</i> , that (I) (we) lost saw the deceased alive on <i>12-23 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Chris Papadopoulos</i> | | | | | 23B. DATE SIGNED <i>12-24-65</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Chris Papadopoulos</i> | | | | | 23D. ADDRESS <i>South Baltimore General Hospital</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | | 24B. DATE <i>12/28/65</i> | | | | |
| 24C. NAME of CEMETERY or CREMATORY <i>Baltimore National</i> | | | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1965</i> | | | | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | | | |
| 25C. FUNERAL DIRECTOR <i>Joseph L. Howard</i> | | | | | 25D. ADDRESS <i>3555 W. North</i> | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 13333</u> | |
|---|------------------------------|--|--|--|--|
| BIRTH NO. <u>65 13333</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. <u>65 13333</u> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>COX, Alonzo</u> | | | 2. DATE AND HOUR OF DEATH <u>12/25/65</u> <u>3:00 P.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>26-34</u> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>1013 Hewitt Way - 21205</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>11/16/99</u> | 9. AGE (in years last birthday) <u>66</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Hiram</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mildred Miller</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>244-24-2094</u> | 17. INFORMANT ADDRESS <u>RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224</u> | | |
| 18. <u>493X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>SHOCK</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>SEPTICEMIA</u> <u>PNEUMONIA</u> | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>1 day</u> <u>3 days</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>HT/AS LUP</u> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/25</u> 19 <u>65</u> to <u>12/25</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>G. Gey</u> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/25/65</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>G. Gey</u> | | | 23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue, Baltimore, Md. 21224</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>12-29-65</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore (Maryland)</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>John C. Miller Inc-6415 Belair Rd.-21206</u> | |

10/10/10

21/10/10

1/11/10

19/11/10

YES

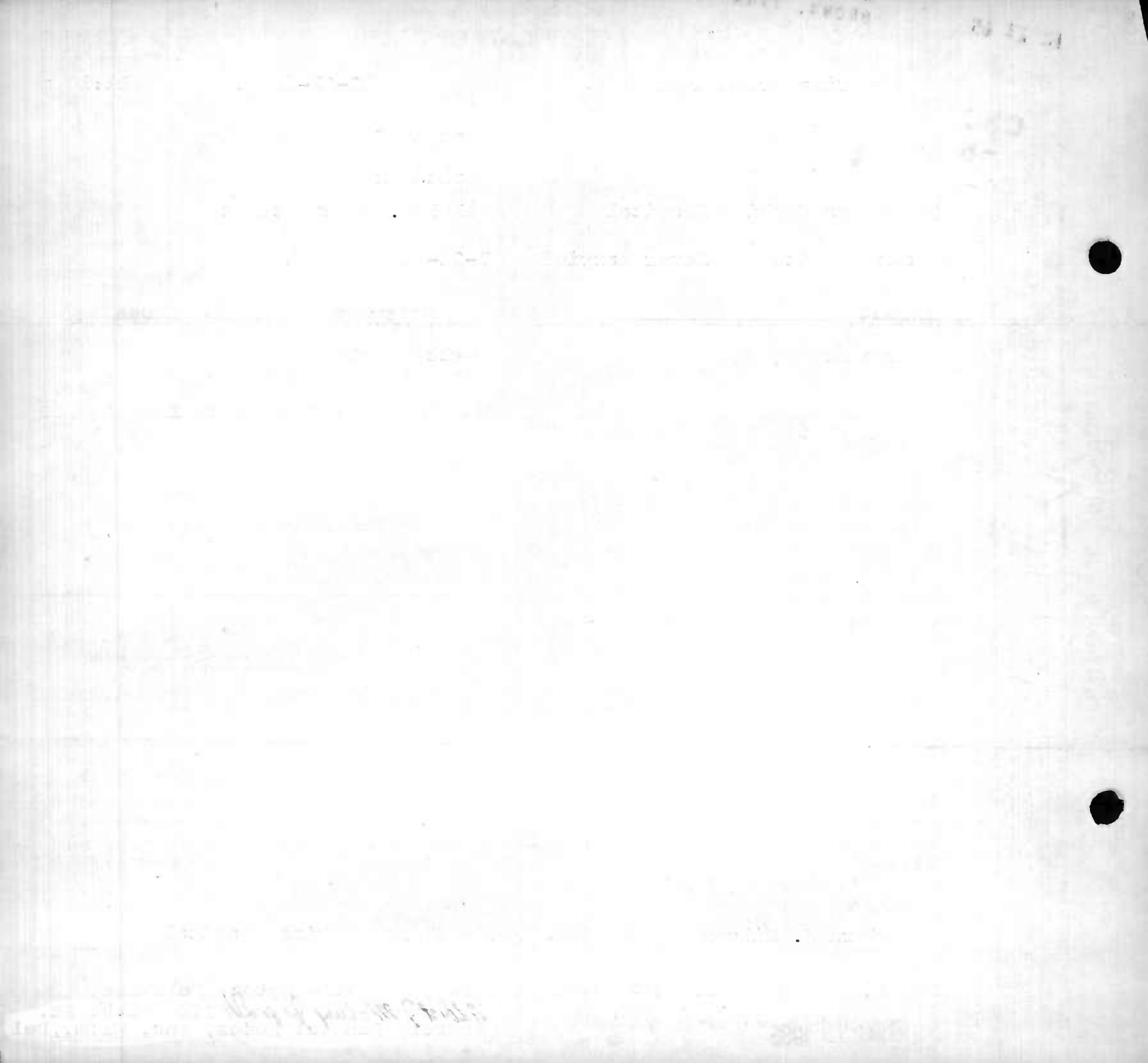
1/12/10

12/12/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13334 | |
|--|--|---------------------------|---|-------------------------|--|
| BIRTH NO. 17334 | | M.E. CASE NO. Brown, Tina | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Tina Lynn Brown | | | 2. DATE AND HOUR OF DEATH 12-23-65 11:10 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | A. STATE Maryland B. COUNTY Baltimore | | |
| 5. SEX Female | | | 6. RACE White | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | | | 8. DATE OF BIRTH 7-21-64 | | |
| 9. AGE (In years last birthday) 1 | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | |
| 11. BIRTHPLACE (State or foreign country) Delaware | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME George E. Brown, Jr. | | | 14. MOTHER'S MAIDEN NAME Betty Revis | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Mr. George E. Brown, Jr. | | | ADDRESS Rt. 40 Bear, Del. Box 22 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Surgery for correction of hydrocephalus | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydrocephalus | | |
| 20A. AUTOPSY? (Yes or No) YES | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 15, 1965 to December 23, 1965, that (I) (we) last saw the deceased alive on December 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bjorn W. Nilson | | | 23B. DATE SIGNED 12/23/65 | | |
| 23C. PHYSICIAN'S NAME (Type) M.D. The Johns Hopkins Hospital | | | 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 12/28/65 | | |
| 24C. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park | | | 24D. LOCATION Wilmington, Delaware | | |
| 25A. DATE REC'D BY HEALTH DEPT. 12/29/65 | | | 25B. NAME OF REGISTRAR Albert J. McCrery, Jr. | | |
| 25C. ADDRESS 2700 Wash. St. Albert J. McCrery, Jr. Wilm., Del. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|------------------------------------|---|---|--|--|
| BIRTH NO. W256 65 13335 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13335 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ESTHER K WAGNER | | | | 2. DATE AND HOUR OF DEATH DECEMBER 27 1965 7:00P | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 99 C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE D. STREET ADDRESS (If rural, give location) 110 FOURTH AVENUE S.W. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-23-00 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JOHN KRESS | | | | 14. MOTHER'S MAIDEN NAME SARA Baylor | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS AVE. AND CATON AVE. ST. AGNES HOSPITAL RECORDS - WILKENS | | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH Carcinoma of the Breast (A) DUE TO Flaring of Effusion (B) DUE TO Gen. Carcinomatous (C) | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 25 19 65 to DECEMBER 27 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Alberto Palacio | | | | 23B. DATE SIGNED 12/27/65 | | 23C. PHYSICIAN'S NAME (Type) ALBERTO PALACIO | |
| 23D. ADDRESS ST. AGNES HOSPITAL | | 23E. M.D. | | 23F. ADDRESS ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY Union Cemetery | | 24D. LOCATION (City, town, or county) (State) Glen Rock, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie | | 25D. ADDRESS | |

Secretary of the Board
of Education
New York City

Wm. J. Schuchman

4/27/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13336 | | CERTIFICATE OF DEATH | | Registered No. 65 13336 | |
|--|---------------------|--|---|--|---|--|------------------------------|-------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <i>Robertson Mable</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/25/65 1830 A.M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3 THE JOHNS HOPKINS HOSPITAL</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore MD 21220 53-00</i> D. STREET ADDRESS (If rural, give location) <i>6 IRIS LANE</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>7/11/98</i> | 9. AGE (In years last birthday) <i>67</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>md.</i> | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <i>JOHN HANKEY</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mary A. Piper</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <i>220-14-6799</i> | | | 17. INFORMANT <i>M. Joseph Passauer</i> | | | ADDRESS <i>(same as above)</i> | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Pancreas</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (A) DUE TO | | (B) DUE TO | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>12.17</i> <i>19 65</i> to <i>12.25</i> <i>19 65</i> , that (I) (we) last saw the deceased alive on <i>12.25</i> <i>19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Herman K. Gold</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <i>12.25.65</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Herman K. Gold</i> | | | |
| 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | |
| 24B. DATE <i>12-29-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holly Hill Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto., Co. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Fink</i> | | 25C. FUNERAL DIRECTOR <i>Comely Funeral Home</i> | | 25D. ADDRESS <i>300 Mac A</i> | | | | | |

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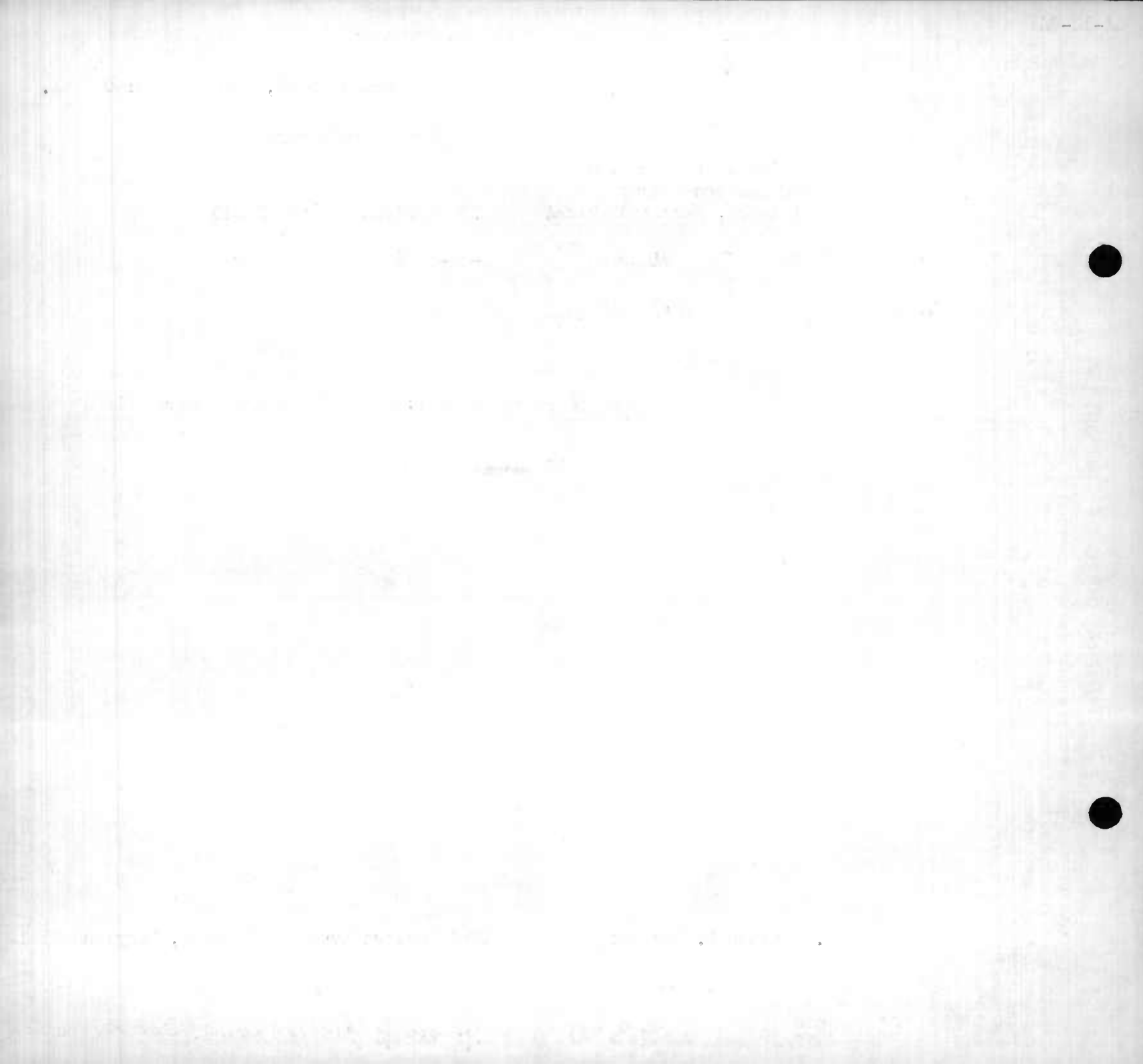
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W-452

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13337 | |
|---|--|--|--|--|--|
| BIRTH NO. 65 13337 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GRACE A. WILLIAMS | | | |
| 2. DATE AND HOUR OF DEATH | | December 26, 1965 9:50 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Maryland Baltimore | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | |
| 8. DATE OF BIRTH 5-24-1886 | | 9. AGE (In years last birthday) 79 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Samuel J. Williams | |
| 14. MOTHER'S MAIDEN NAME Emma C. ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 233-38-5494 | |
| 17. INFORMANT RECORDS: BCH | | ADDRESS 4940 Eastern Avenue 21224 | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO CVA | | | |
| ANTECEDENT CAUSES | | (B) DUE TO MULTIPLE CVA's | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) ASCVD | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/15 19 65 to 12/26 19 65, that (I) (we) last saw the deceased alive on 12/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Clayton L. Moravec M.D. | | | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Clayton L. Moravec | | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-29-65 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Park Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balt., Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Faltano | | 25C. FUNERAL DIRECTOR Connelly Funeral Home - 300 Prince Georges Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

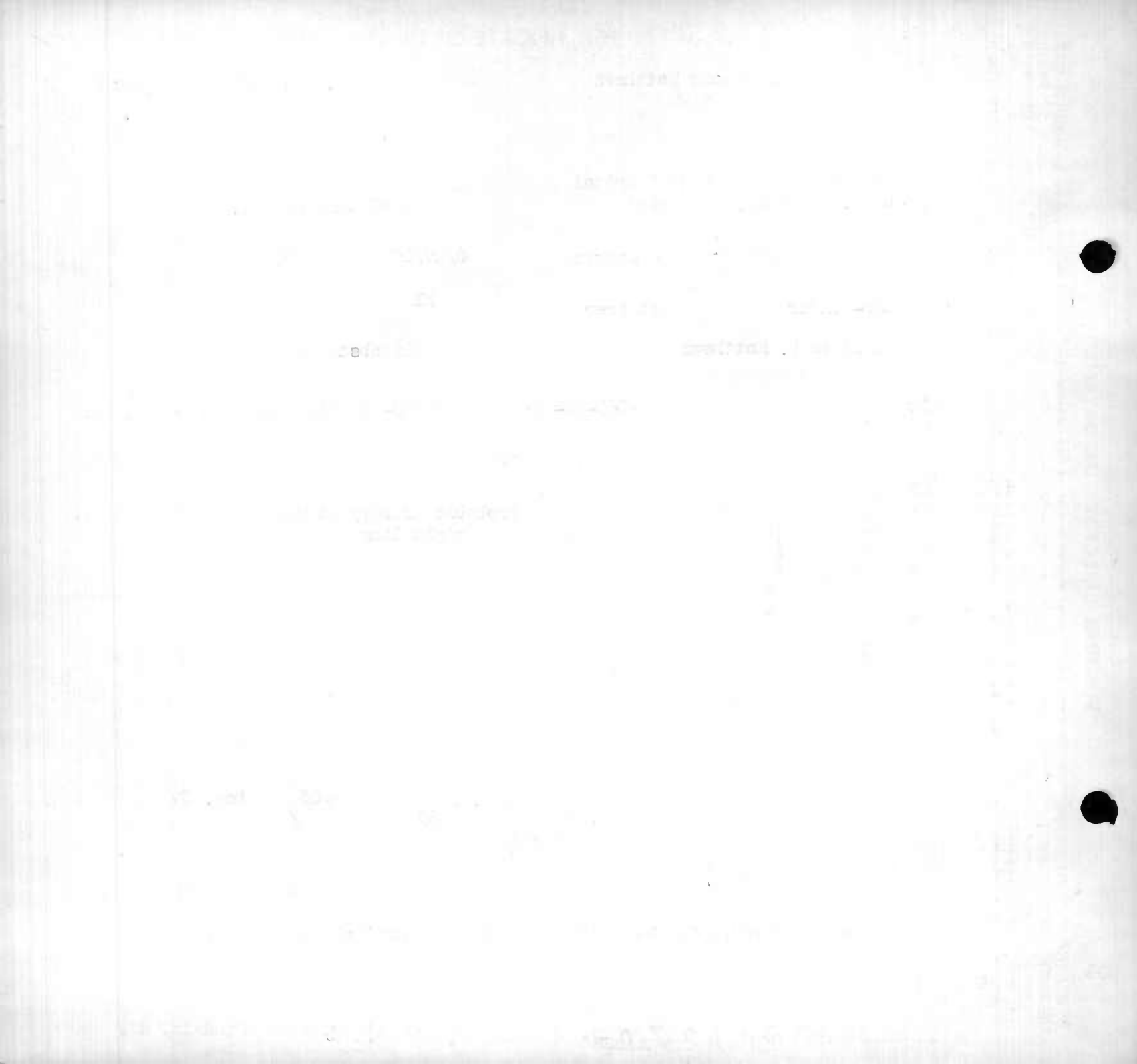
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 13338 | |
|--|---------------------|--|---|--|--|
| BIRTH NO. | | | | 65 13338 | |
| M.E. CASE NO. | | | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) ELSIE ROLLINS | | | 2. DATE AND HOUR OF DEATH 12/28/65 6:20 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL | | | A. STATE MARYLAND B. COUNTY BALTO | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | | |
| | | | D. STREET ADDRESS (If rural, give location) 2713 McCOMAS AVE | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8/30/12 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) BALTO, MD. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME WILLIAM LAIB | | | 14. MOTHER'S MAIDEN NAME CATHERIN LAIB (UNKNOWN) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS HUSBAND SAME | | |
| 18. 416X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RHEUMATIC HEART DISEASE DUE TO WITH RHEUMATIC HEART DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH 40 YEARS | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/21 19 65 to 12/28 19 65 , that (I) (we) last saw the deceased alive on 12/28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ronald Goldney | | | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) RONALD GOLDNEY | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/28/65 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Fagley | |
| 25C. FUNERAL DIRECTOR James H. Connolly | | 25D. ADDRESS 300 main ave 21 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

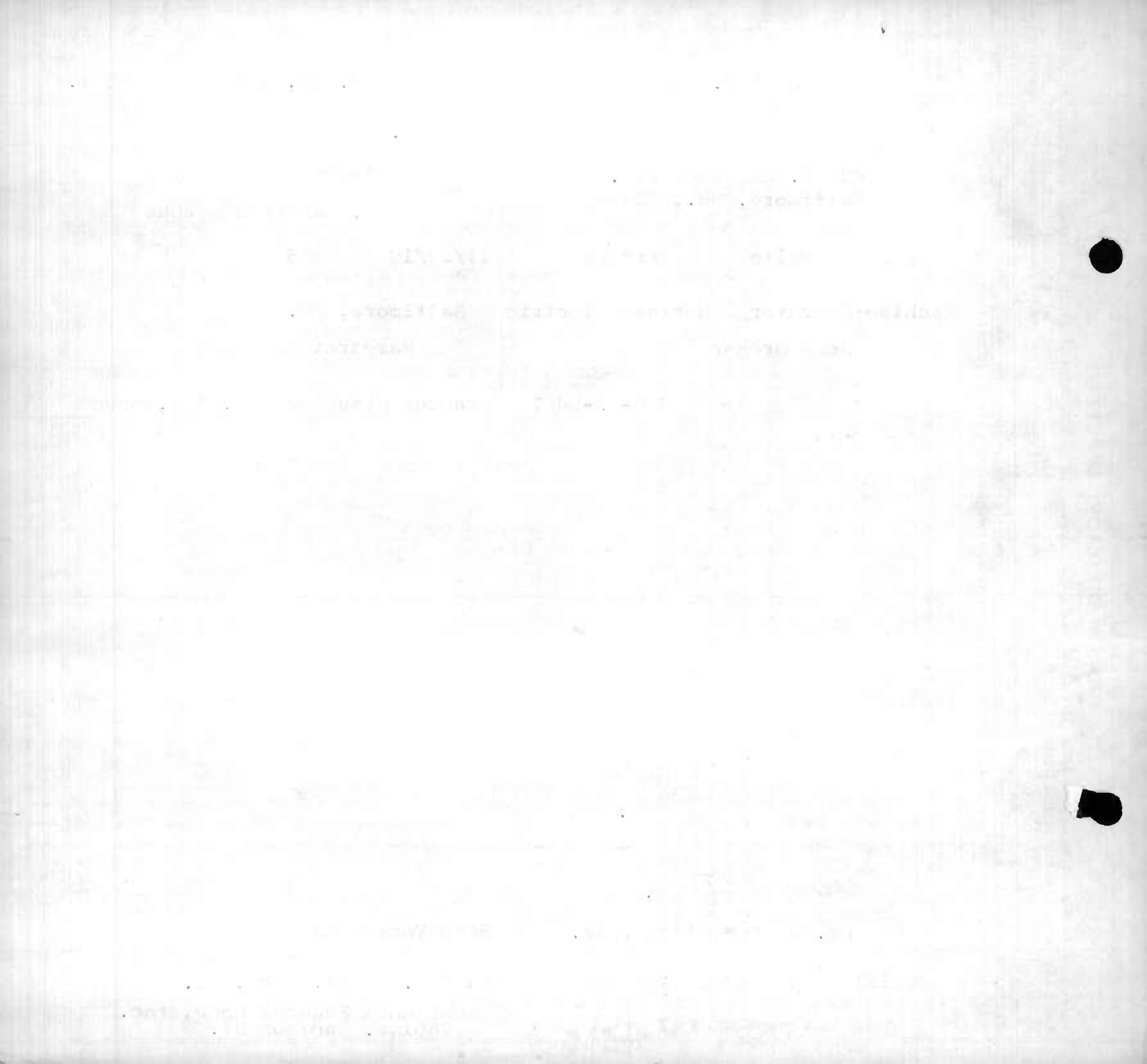
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--------------|--|--|--|---|--|---|--|-------------------------------------|
| BIRTH NO. 65 13339 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 13339 | | | | |
| 1. NAME OF DECEASED (Type or Print) William Howard Matthews | | | | | 2. DATE AND HOUR OF DEATH Dec. 27, 1965 10:20 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8222 Dundalk Ave. | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6/27/10 | 9. AGE (In years last birthday) 55 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water-tender | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William H. Matthews | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Pflieger | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 063-01-9981 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis Probable primary carcinoma right lung | | | | | INTERVAL BETWEEN ONSET AND DEATH Weeks Months | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 1 1965 to Dec. 27 1965, that (I) (we) last saw the deceased alive on Dec. 27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE James M. Weaver M.D. | | | | | 23B. DATE SIGNED 12/28/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director M.D. | | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-31-65 | | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Ulrich Funeral Home | | 25D. ADDRESS Dundalk, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

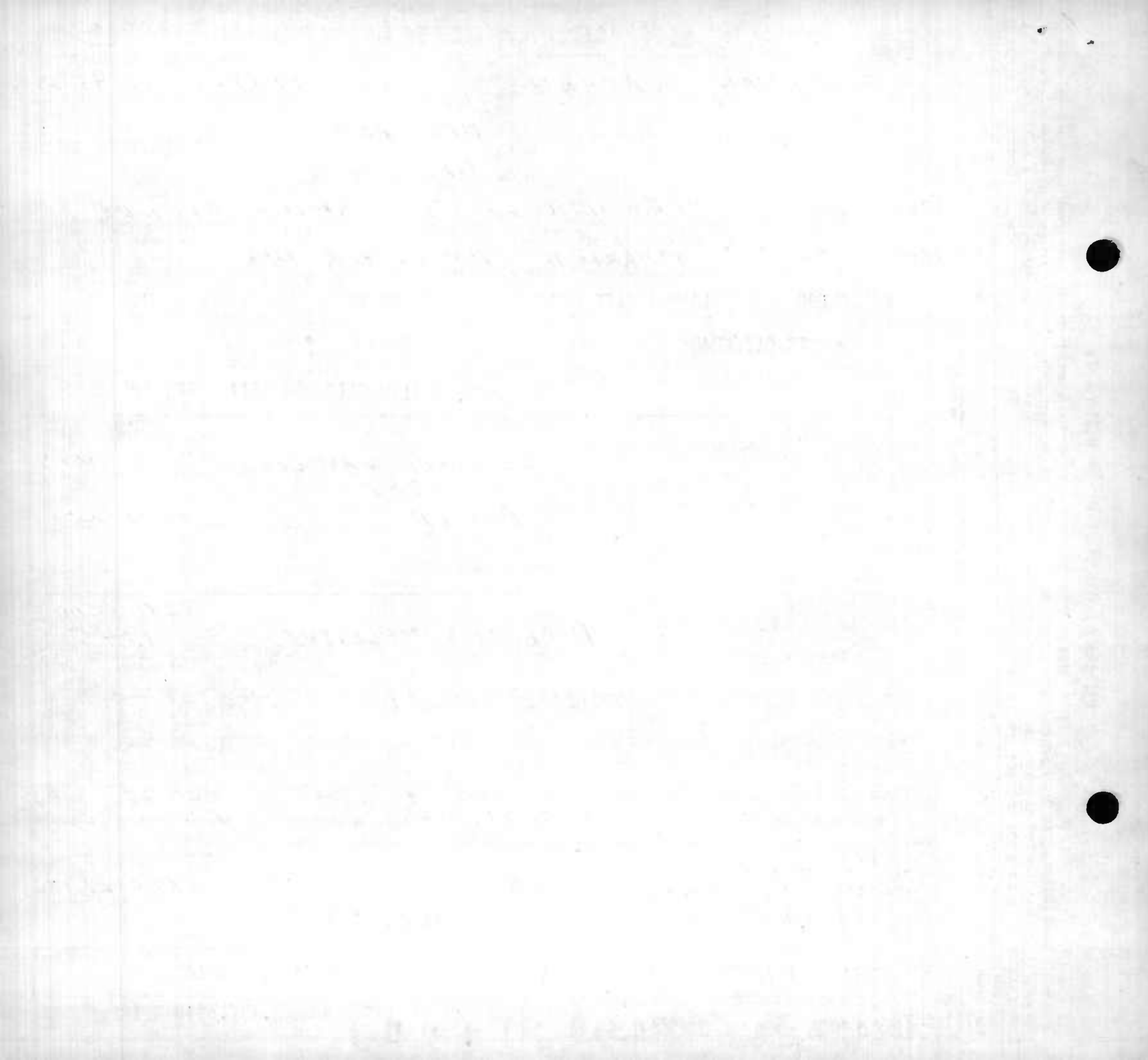
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|--|-------------------------|--|--|--|---|
| BIRTH NO. 65 13340 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13340 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JOHN J. GREGER | | | 2. DATE AND HOUR OF DEATH Dec. 28, 1965 5 a. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 439 N. Lakewood Ave., Baltimore, Md., 21224 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 6-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 439 N. Lakewood Avenue | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | B. DATE OF BIRTH 11/29/10 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Western Electric | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME John Greger | | | 14. MOTHER'S MAIDEN NAME Margaret Barnicle | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-03-0407 | | 17. INFORMANT ADDRESS Frances Hines Greger, wife, above | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) Carcinoma of esophagus DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION 12/28/65 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work At <input type="checkbox"/> Home | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 12 19 65 to 12/28/65 19 65 and that (I) (we) last saw the deceased alive on 12/28/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. George Finney, Jr. | | | 23B. DATE SIGNED 12/28/65 | | 23C. PHYSICIAN'S NAME (Type) Dr. George Finney, Jr. |
| 23D. ADDRESS 5820 York Road | | | 23E. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem. | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. ADDRESS 2601 E. Madison St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

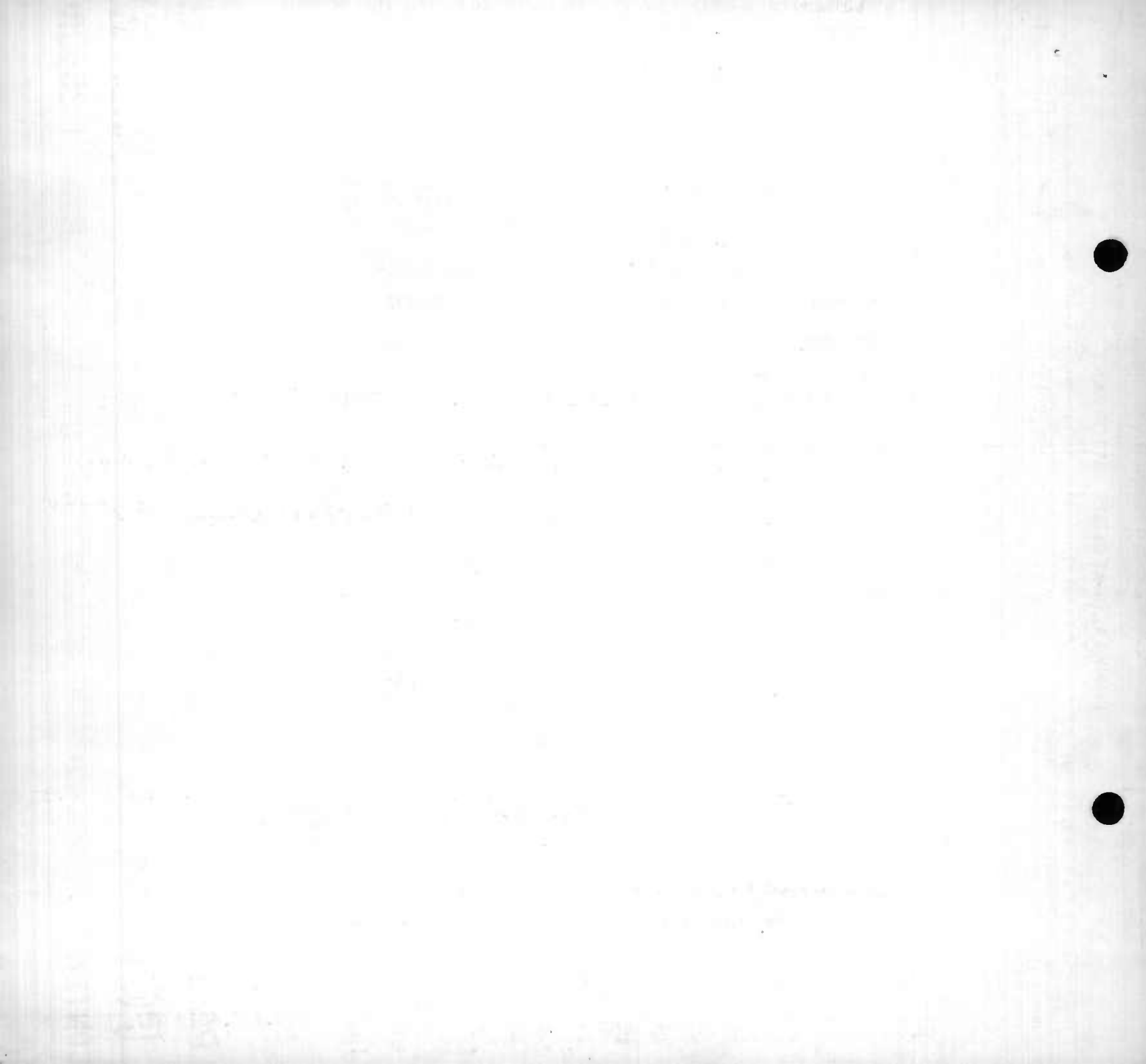
| BIRTH NO. 65 13341 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13341 | |
|---|-------------------------|--|--|--|--|--|-----------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) GLICKMAN, NATHAN | | | | 2. DATE AND HOUR OF DEATH DEC. 27, 1965 12:45 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC | | | | A. STATE MARYLAND | | B. COUNTY BALTO | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| | | | | D. STREET ADDRESS (If rural, give location) 3311 SMITH AVENUE | | | | | |
| 5. SEX MALE | 6. RACE CAUC. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH MAR. 23, 1886 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR | | 10B. KIND OF BUSINESS OR INDUSTRY LAMP & GIFT SHOP | | 11. BIRTHPLACE (State or foreign country) LITHUANIA | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME MORRIS GLICKMAN | | | | 14. MOTHER'S MAIDEN NAME MINNA ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. ROSLYN GLICKMAN | | ADDRESS 3311 SMITH AVENUE | | | |
| 18. 402.1V-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL VASCULAR ACCIDENT | | | | CAUSE OF DEATH (A) CEREBRAL VASCULAR DUE TO ACCIDENT (B) ASCVD DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH 8 DAYS UNKNOWN | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS | | | | 20. YEARS 20 YEARS 1945 | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC. 19 1965 to DEC. 27 1965 , that (I) (we) last saw the deceased alive on DEC. 27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Herbert Fellerman | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED DEC 27, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) HERBERT FELLERMAN | | | | 23D. ADDRESS SINAI HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/29/65 | | 24C. NAME of CEMETERY or CREMATORY AHAVA'S SHOLOM | | 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR SOL LEVINSON | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. | | ADDRESS 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13342 | |
|---|-------------------------|--|------------------|---|---|
| BIRTH NO. 65 13342 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) DAVID ELIE TAYLOR | | 2. DATE AND HOUR OF DEATH DECEMBER 28, 1965 6:45 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-18 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4003 HAYWARD AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY INSURANCE | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW1 ARMY | | 16. SOCIAL SECURITY NO. 050-14-8764 | | 17. INFORMANT MRS. ROSE TAYLOR ADDRESS 4003 HAYWARD AVENUE | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY OCCLUSION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic Heart Disease | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) none | | INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 6 1962 to Dec 28 1965 , that (I) (we) last saw the deceased alive on Dec 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel Levin | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED DECEMBER 29, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) DR. MANUEL LEVIN | | 23D. ADDRESS 4818 REISTERSTOWN ROAD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12/30/65 | | 24C. NAME OF CEMETERY or CREMATORY MOSES MONTIFILORE | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. ADDRESS 6010 REISTERSTOWN RD | |



FUNERAL DIRECTOR: IMPORTANT

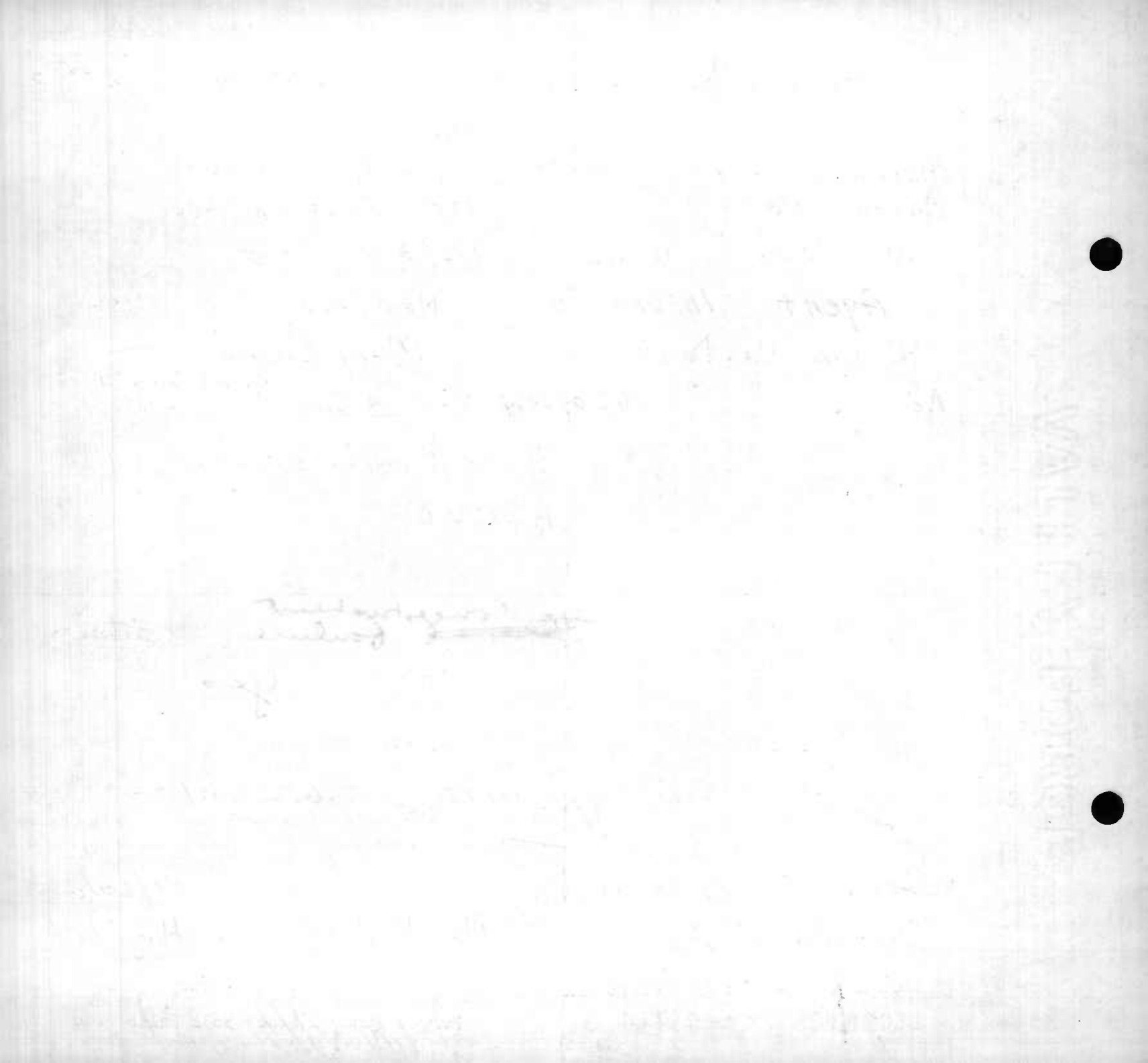
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|---|---|--|--|
| BIRTH NO. 65 13343 | | Baltimore City Health Department CERTIFICATE OF DEATH | | Registered No. 65 13343 | |
| 1. NAME OF DECEASED (Type or Print) Mrs. Eloise V. Marston | | | 2. DATE AND HOUR OF DEATH December 27, 1965 3:10 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4257 Falls Road | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-14 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4257 Falls Road | | |
| 5. SEX Female | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH May 18, 1889 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry worker | | 10B. KIND OF BUSINESS OR INDUSTRY School | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Frank R. Palmer | | | 14. MOTHER'S MAIDEN NAME Hannah Virginia Keefer | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs. Sandra Worden | | |
| | | | ADDRESS 4257 Falls Road | | |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Metastatic Carcinoma Lung thru ducts DUE TO (B) Carcinoma Rt. Breast DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) / | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 27 December 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. E. Proctor | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 29 Dec 1965 |
| 23C. PHYSICIAN'S NAME (Type) S. E. Proctor | | | 23D. ADDRESS 104 W Madison St Balto Md | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 30 Dec 65 | 24C. NAME OF CEMETERY or CREMATORY St. Mary's (Hampden) | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Dodge Funeral Home 3631 Falls Rd | |
| | | | | ADDRESS 1114 ... | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

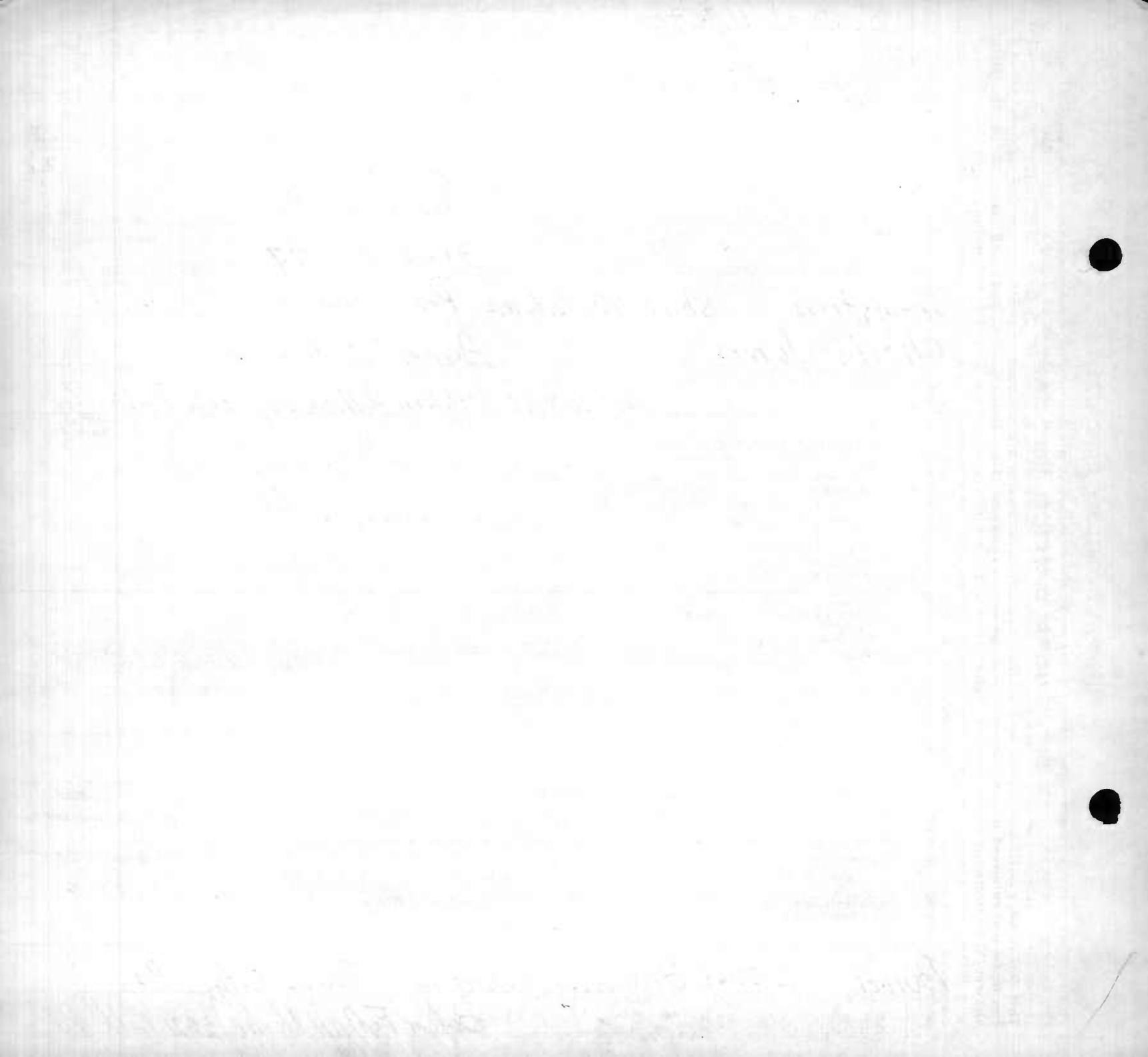
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13344 | |
|---|----------------|---|------------------------------|--|--|
| BIRTH NO. 65 13344 | | CERTIFICATE OF DEATH | | Registered No. 65 13344 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Howard R. Van Droof | | 2. DATE AND HOUR OF DEATH Dec 28, 1965 2:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital Baltimore Md | | A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21209 33-00 D. STREET ADDRESS (If rural, give location) 1207 Fairfield Ave | | | |
| 5. SEX m | 6. RACE Cau | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 9/2/1890 | 9. AGE (In years last birthday) 75 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent | | 10B. KIND OF BUSINESS OR INDUSTRY Insurance | | 11. BIRTHPLACE (State or foreign country) New Jersey | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William Van Droof | | 14. MOTHER'S MAIDEN NAME Mary Emma | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 142 090064 | | 17. INFORMANT Ralph Van Droof Address Chart & Son Same Address | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) ASCVD DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 Hr | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Congestive heart failure | | | | 3 days | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/25 1965 to 12/28 1965, that (I) (we) last saw the deceased alive on 12/28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald T. Lewers M.D. | | | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) DONALD T. LEWERS | | 23D. ADDRESS Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 31 Dec 65 | | 24C. NAME OF CEMETERY or CREMATORY Locust Hill Cemetery | |
| 24D. LOCATION Dover, New Jersey | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Burgee Funeral Home | | 25D. ADDRESS 3631 Falls Road | |



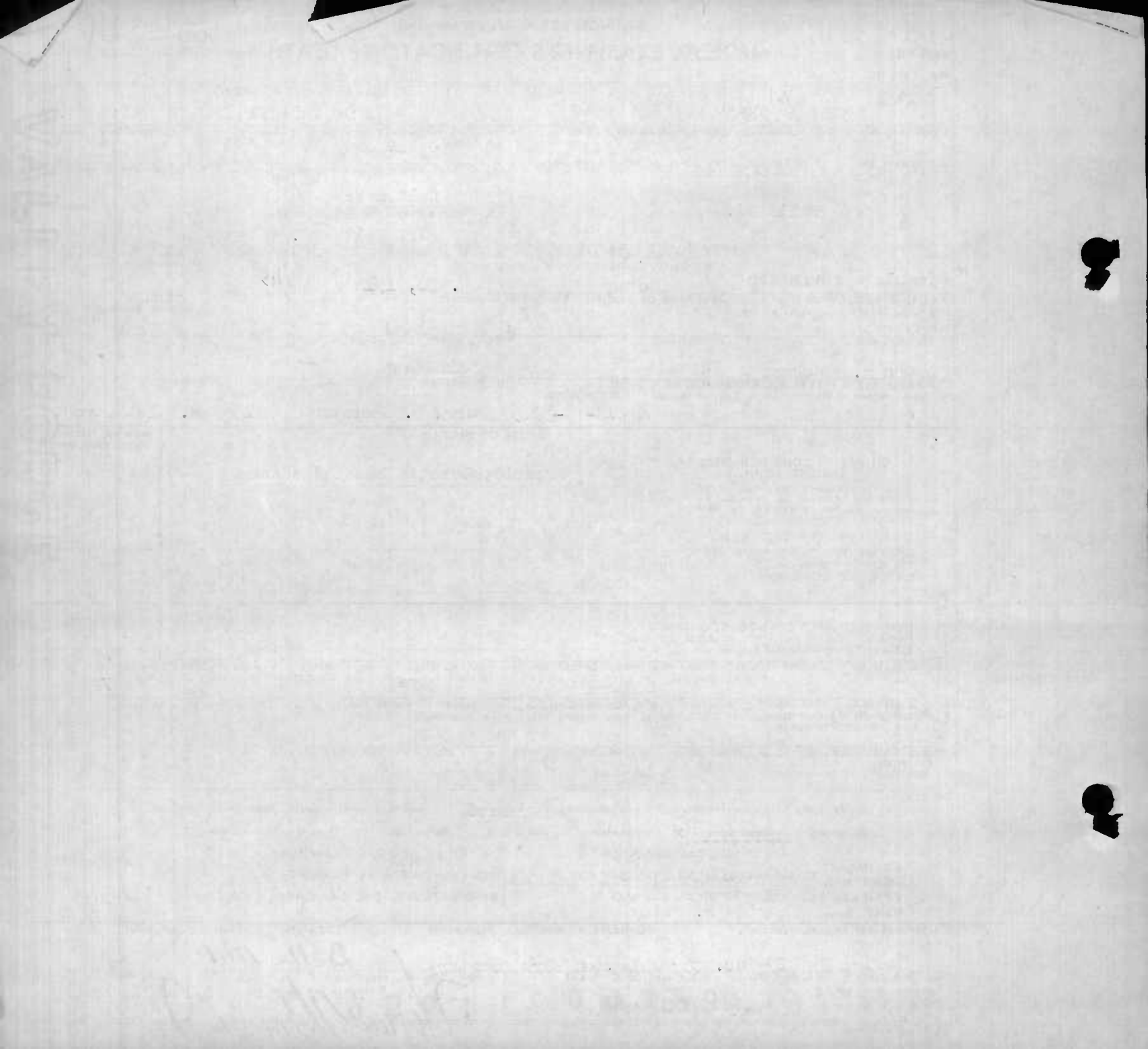
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <i>Susie J. White</i> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <i>65 13345</i> | |
|--|---------------------|--|------------------------------------|--|-----------------------|---|------------------------|
| M.E. CASE NO. <i>65 13345</i> | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Susie J. White</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/22/65 5:10 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>MD</i> | | B. COUNTY <i>Baltimore</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>4238 Falls Road</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>3/25/88</i> | 9. AGE (In years last birthday) <i>77</i> | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Shirt Manufacturer</i> | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Charles Jones</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Agnes Bateman</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>213 208985</i> | | 17. INFORMANT <i>Kathleen A. Mowery</i> | | ADDRESS <i>4238 Falls Rd</i> | |
| 18. <i>334X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>cerebrovascular insufficiency</i> | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Atherosclerosis</i> | | | | (B) DUE TO | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/21</i> 19 <i>65</i> to <i>12/22</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/22</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/22/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-27-65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Greenwood Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Tower City PA</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1965</i> | | 25B. NAME OF REGISTRAR <i>[Signature]</i> | | 25C. FUNERAL DIRECTOR <i>Bryce Funeral Home</i> | | ADDRESS <i>3631 Falk Rd</i> | |



| 65 13346 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13346 | |
|--|-----------------------------|--|---|--|---|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) BERTHA SHERMAN | | | 2. DATE AND HOUR PRONOUNCED DEAD 25 December 1965 11:00 a. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3427 Falls Rd. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-06 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3427 Falls Rd. | | |
| 5. SEX female | 6. RACE caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Feb. 16, 1916 | 9. AGE (In years last birthday) 49 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John H. Kaufman | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 213-20-5269 | | 17. INFORMANT Harry M. Sherman |
| | | | ADDRESS 1353 W. 41st Street | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Charles S. Petty | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED |
| EXAMINER'S NAME (Type) Charles S. Petty | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 12/26/65 |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 29 Dec. 65 | | 23C. NAME of CEMETERY or CREMATORY London Park Cemetery | |
| 23D. LOCATION (City, town, or county) (State) Belts Md | | | | | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 24B. NAME OF REGISTRAR Robert E. Fadden | | 24C. FUNERAL DIRECTOR Bungee Funeral Home | |
| | | ADDRESS 3631 Falls Road | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|--|-------------------------|--|--|
| BIRTH NO. 65 13347 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13347 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) HARRIS, LEWIS GRIMM | | 2. DATE AND HOUR OF DEATH 12/23/65 10 05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY | |
| UNION MEMORIAL HOSP | | BALTIMORE | | 13-8 | |
| D. STREET ADDRESS (If rural, give location) | | 3526 POOLE ST. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED , NEVER MARRIED WIDOWED , DIVORCED (specify) Single | 8. DATE OF BIRTH 3/1/91 | 9. AGE (In years last birthday) 74 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME THOMAS O. HARRIS | | 14. MOTHER'S MAIDEN NAME KATHERINE A. BROOKERS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CATHERINE HARRIS | |
| 18. 201X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO Nodeknis disease | | 2 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 12/19/65 to 12/23/65, that (we) lost saw the deceased alive on 12/23/65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Robert N. Whitlock | | 23B. DATE SIGNED 12/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT N. WHITLOCK | | 23D. ADDRESS Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-28-65 | | 24C. NAME of CEMETERY or CREMATORY Woodlawn Cem | |
| 24D. LOCATION B2/Ho Co. Md | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert N. Whitlock | |
| 25C. FUNERAL DIRECTOR Duke Funeral Home | | 25D. ADDRESS 3631 Falls Rd | | | |

15/5/51 15/5/51 15/5/51

MANUALLY

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MARKED

120

KATHERINE A. BROOKS

326 3006 21

KATHERINE HARRIS

Industrial Revolution 2 weeks

Industrial Revolution 2 weeks

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4

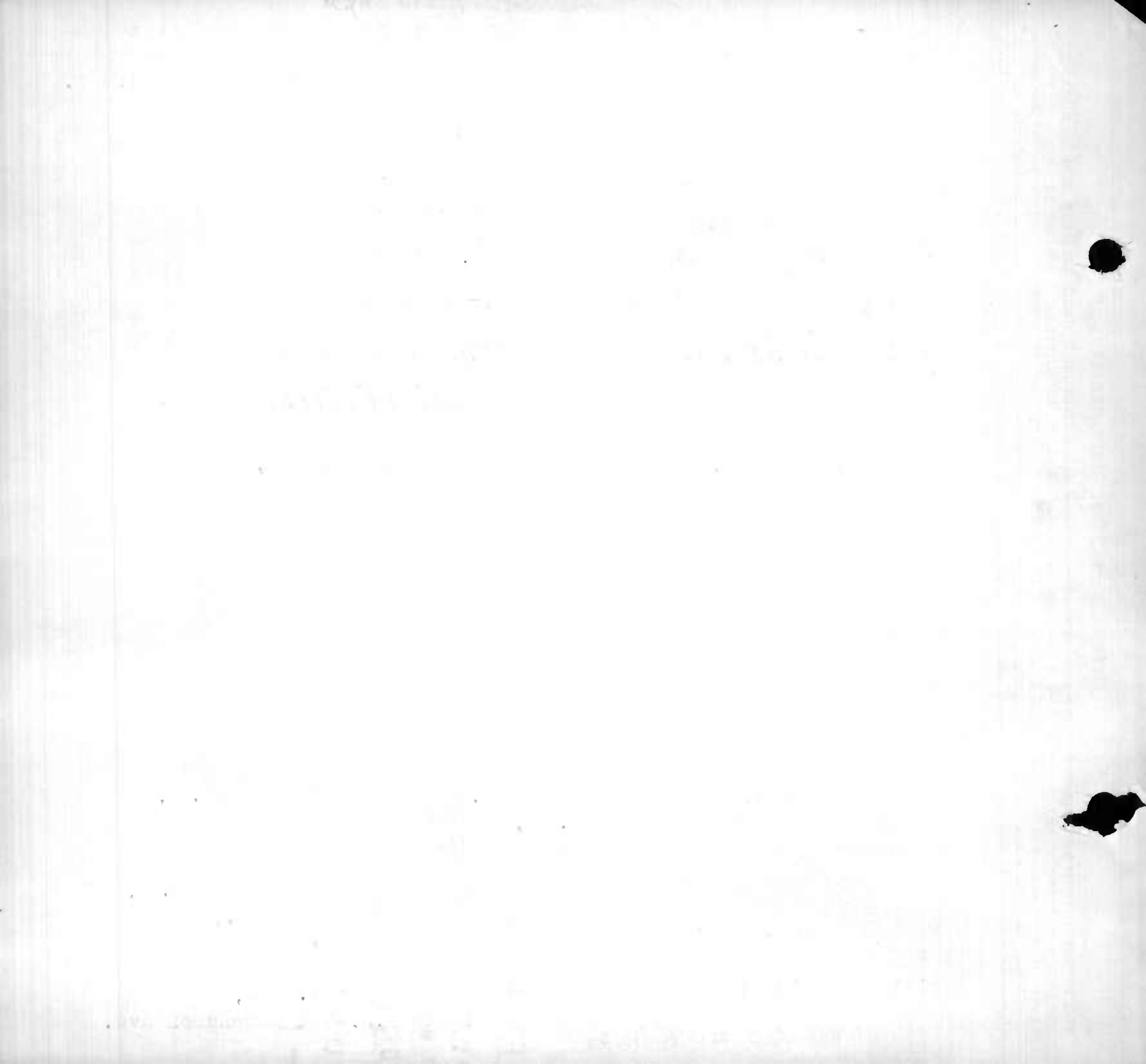
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15/5/51 15/5/51

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

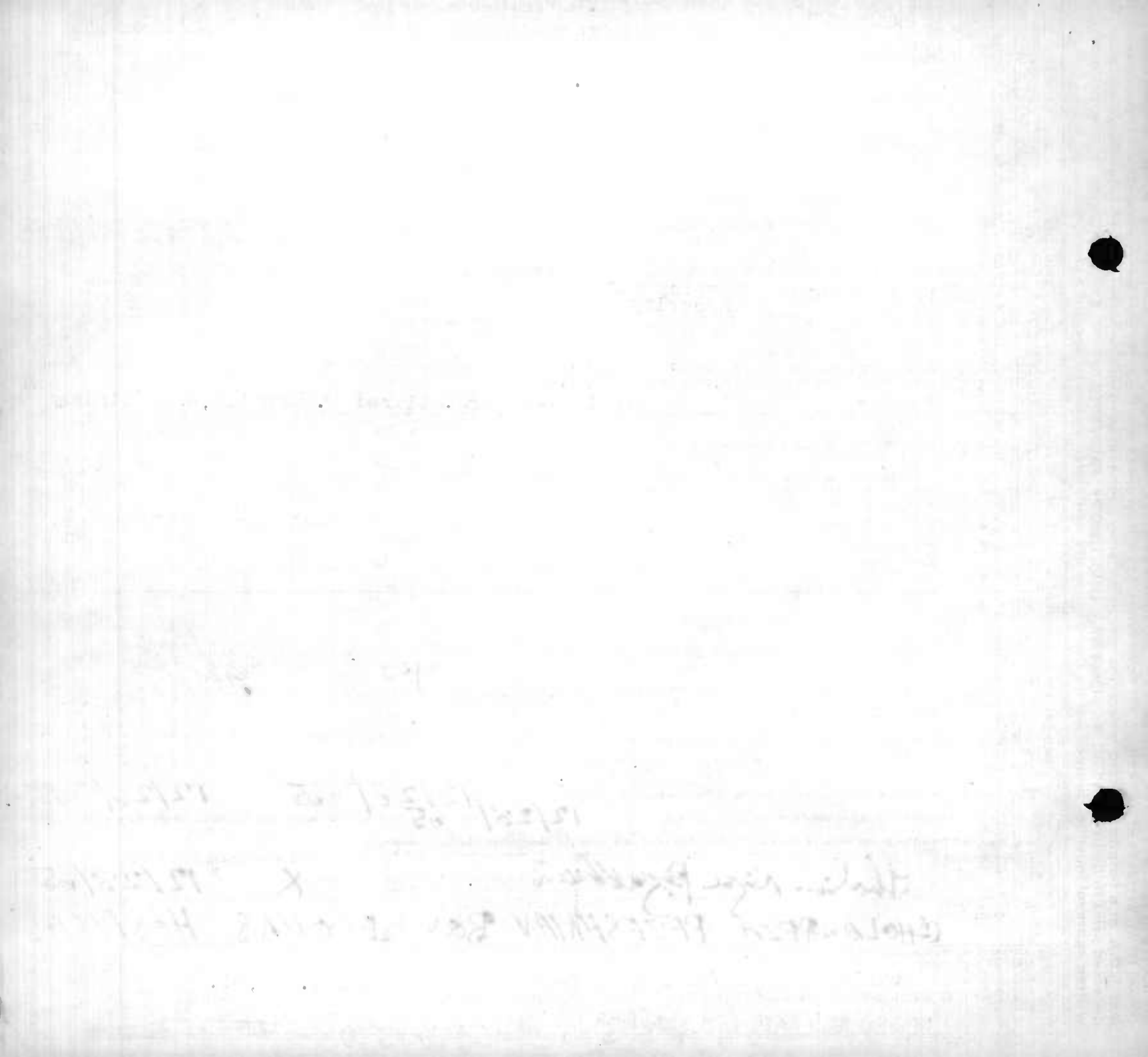
| BIRTH NO. 65 13348 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13348 | |
|--|---------------|--|------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MARIA T. POTTAST | | | | 2. DATE AND HOUR OF DEATH DEC. 29, 1965 1:30 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 5115 GREENWICH AVE. | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND 28-04 | | B. COUNTY BALTIMORE | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | | | |
| 5115 GREENWICH AVE. | | | | | | | |
| 5. SEX 7 | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3/4/1983 | 9. AGE (in years last birthday) 82 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 11. BIRTHPLACE (State or foreign country) GERMANY |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John SCHENKE | | | | 14. MOTHER'S MAIDEN NAME Theresa Gabisch | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Berthold POTTAST | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | 19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) this hospital attended the deceased from Dec. 1965 to Dec. 29, 1965, and that (2) the lost saw the deceased alive on Dec. 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Leo J. Gaver | | | | 23B. DATE SIGNED Dec. 29, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) Leo J. Gaver | | | | 23D. ADDRESS 1 Mallow Hill Ave., Baltimore, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Balto. 29, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | BIRTH NO. 65 13349 | | REGISTERED NO. 65 13349 | |
| M.E. CASE NO. 3 | | BIRTH NO. 65 13349 | | REGISTERED NO. 65 13349 | |
| 1. NAME OF DECEASED (Type or Print) GRABILL, Edward W. | | | 2. DATE AND HOUR OF DEATH 12 / 28 / 65 6 45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND BON SECOURS HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 28-04 | | |
| 5. SEX MALE | | | 6. RACE CAUCASIAN | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | | 8. DATE OF BIRTH 11 / 3 / 98 | | |
| 9. AGE (In years last birthday) 67 | | | 10. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME ROBERT E. GRABILL | | | 14. MOTHER'S MAIDEN NAME ESTHER FRASIER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | | 16. SOCIAL SECURITY NO. 214 10 4432 | | |
| 17. INFORMANT Mrs. Mildred E. Grabill | | | ADDRESS 4926 Lindsay Rd | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RECENT INFARCT OF POSTERIOR WALL OF LEFT VENTRICLE. | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DISEASE | | | years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20C. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (Y) (this hospital) attended the deceased from 12/28/1965 to 12/28/1965 . that (Y) (we) last saw the deceased alive on 12/28/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Gholam Reza Pezeshkian | | | 23B. DATE SIGNED 12/28/65 | | |
| 23C. PHYSICIAN'S NAME (Type) GHOLOM REZA PEZESHKIAN | | | 23D. ADDRESS BON SECOURS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | |
| 24D. LOCATION Balto. 29, Md. | | 24E. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 24F. NAME OF REGISTRAR Robert E. Fairbank | |
| 24G. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 24H. NAME OF REGISTRAR Robert E. Fairbank | | 24I. FUNERAL DIRECTOR Witky 3D | |



65 13350

BALTIMORE CITY HEALTH DEPARTMENT

65 13350

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH L. POLAK

2. DATE AND HOUR PRONOUNCED DEAD

December 29, 1965

6:02 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Pennsylvania

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Philadelphia

D. STREET ADDRESS (If rural, give location)

2084 A South John Circle

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Feb 12, 1896

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY

WOMENS WEAR

11. BIRTHPLACE (State or foreign country)

PHILA, Pa

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Peretz

14. MOTHER'S MAIDEN NAME

LEAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

16. SOCIAL
SECURITY NO.

17. INFORMANT

WIFE

ADDRESS

SAME

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/31/65

23C. NAME of CEMETERY or CREMATORY

Adath Jeshurun

23D. LOCATION

Phila, Pa

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 30 1965

24B. NAME OF REGISTRAR

R. S. G. F. G. G.

24C. FUNERAL DIRECTOR

Sydney S. Lewis & Son Inc 3319

ADDRESS

65 13351

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13351

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLIFTON JONES

2. DATE AND HOUR PRONOUNCED DEAD

December 28, 1965 2:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

826 N. Bentalou Street

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 4, 1910

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Meat Packers

11. BIRTHPLACE (State or foreign country)

Henderson, N. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Jones

14. MOTHER'S MAIDEN NAME

Cora B. Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
217-01-1319

17. INFORMANT

ADDRESS

Irma T. Jones - 826 N. Bentalou St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) Asphyxia due to carbon monoxide poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

garage

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

2300 W. Mosher

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12-28-65 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Apparently overcome by gas fumes

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-1-66

23C. NAME of CEMETERY or CREMATORY

Greenwood Baptist

23D. LOCATION

(City, town, or county)

(State)

Warrenton, N. C.

24A. DATE REC'D BY HEALTH DEPT.

DEC 30 1965

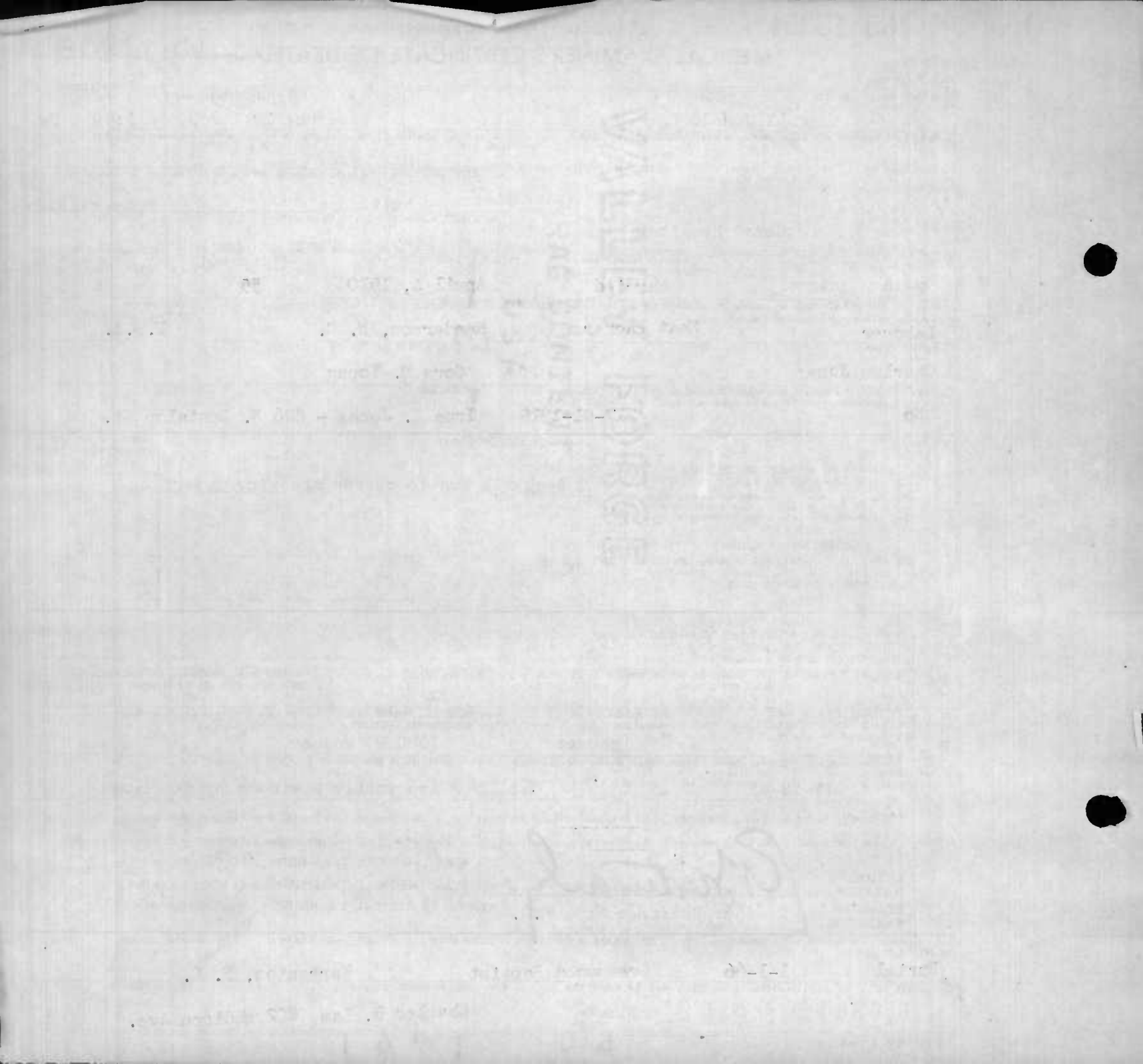
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

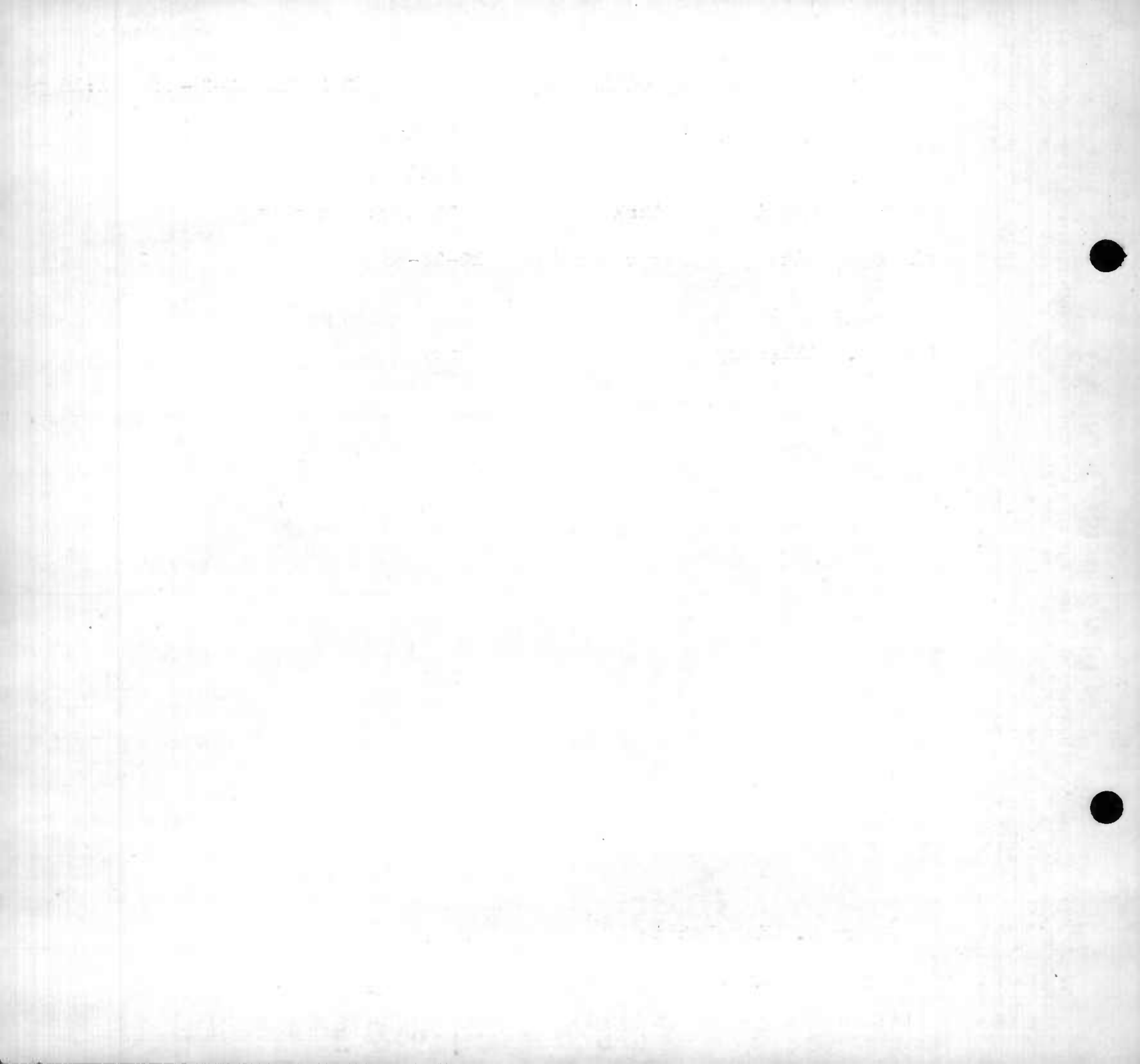
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

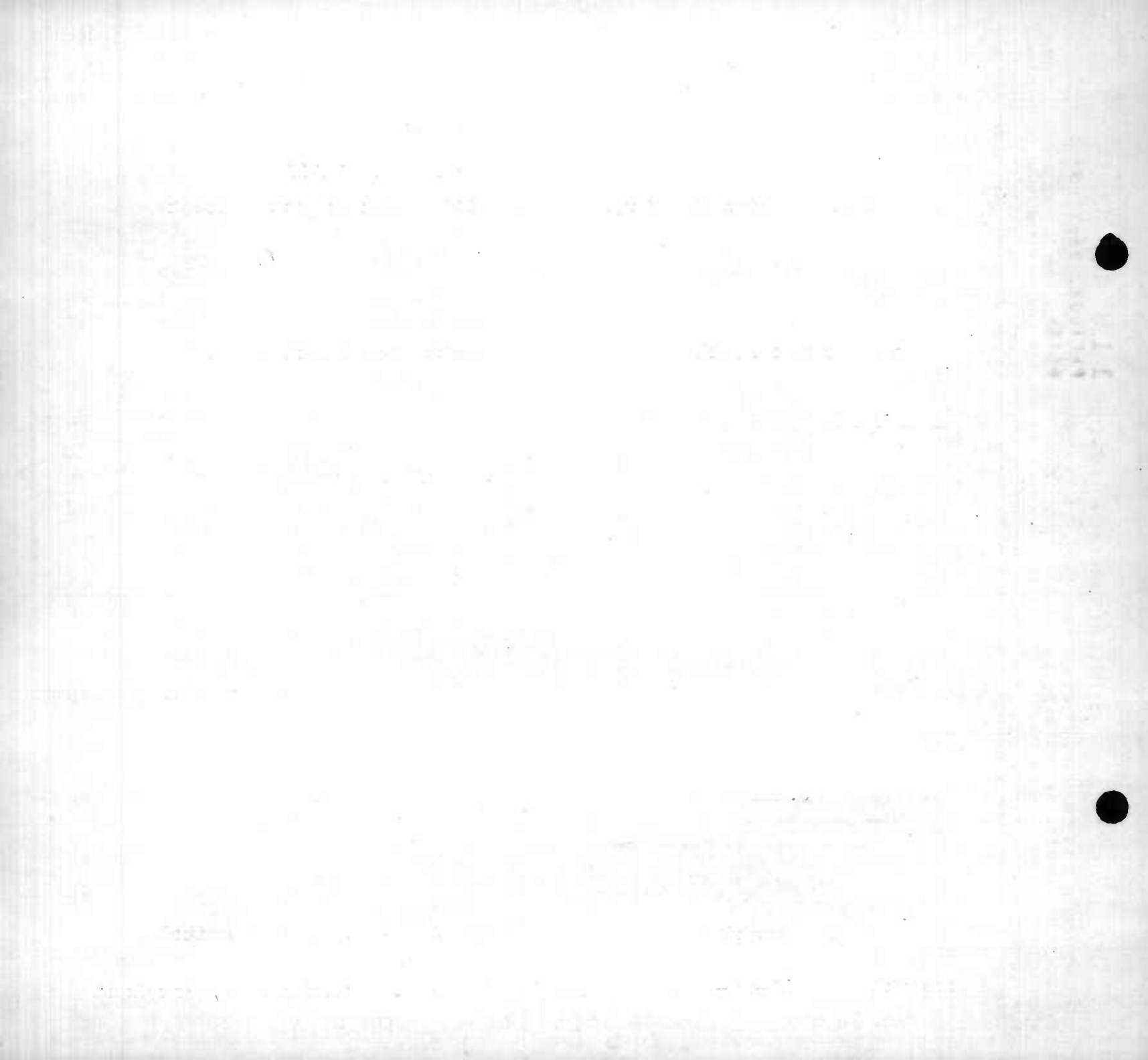
| | | | | | |
|---|-------------------------|---|---|---|--|
| BIRTH NO. <u>65-31450</u> <u>65 13352</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 13352</u> | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>Baby/Boy of Mary Pillsbury</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>7-05</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>821 North Broadway</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>12-26-65</u> | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. <u>2</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <u>John M. Pillsbury</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. <u>762.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Possible Sepsis</u> DUE TO (B) <u>Aspiration Pneumonia</u> DUE TO (C) <u>Anoxic Brain Damage</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (if this hospital) attended the deceased from <u>Dec 26</u> 19 <u>65</u> to <u>Dec 28</u> 19 <u>65</u> , that <u>(we)</u> last saw the deceased alive on <u>Dec 28</u> 19 <u>65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jerry O. Winkelstein</u> M.D. | | | | 23B. DATE SIGNED <u>12/28/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Jerry O. Winkelstein</u> M.D. | | | | 23D. ADDRESS <u>1203 Cathedral St</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 24B. DATE <u>12-29-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Johns Hopkins Hospital</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Falkner</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u> | |



FUNERAL DIRECTOR: IMPORTANT 18 4 46 RS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13353 | |
|---|---------------------|--|--------------------------------------|---|---|
| BIRTH NO. 65-32304 | | 65 13353 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Pretlow Baby Boy of Betty</i> | | 2. DATE AND HOUR OF DEATH <i>29 Dec 65 7¹⁵/AM M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <i>Maryland</i> | | 20-02 | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21223</i> | | D. STREET ADDRESS (If rural, give location) <i>2220 West Fayette Street</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>N</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i> | 8. DATE OF BIRTH <i>28 Dec 65</i> | 9. AGE (In years last birthday) <i>0</i> | If Under 1 Yr. Months Days Hours Min. <i>— — 18 59</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Edward Ernest Pretlow</i> | | 14. MOTHER'S MAIDEN NAME <i>Betty Lee XXXXXX Ford</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <i>762.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Respiratory Distress</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Meconium Aspiration</i> <i>+ possible Brain Damage</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>18 hrs 59 min</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>28 Dec 1965</i> to <i>29 Dec 1965</i> , that (I) (we) lost saw the deceased alive on <i>29 Dec 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Tom Austine</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>29 Dec 65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Tom Austine</i> | | 23D. ADDRESS M.D. <i>The Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 24B. DATE <i>12-29-65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>The Johns Hopkins Hos.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore 5, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>HOSPITAL DISPOSAL</i> | | | |



45-17-11

CRF

65 13354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 13354

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAY, DOROTHY

2. DATE AND HOUR OF DEATH

December 26, 1965 | 2:50 A. M.

CERTIFICATE AMENDED

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland, #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Kingsville

D. STREET ADDRESS (If rural, give location)

Bradshaw Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

1/8-6-1912/8/6/72

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

/PETER/ RICH John Rich

14. MOTHER'S MAIDEN NAME

Katherine Mobran

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-48-5636

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Ave., #21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Respiratory arrest, gradual 2 week

(B) DUE TO

Bilateral CVA, brain at
ischemia

(C)

INTERVAL BETWEEN
ONSET AND DEATH

1 1/2 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-13 19 65 to 12-26 19 65,
that (I) (we) last saw the deceased alive on 12-26 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Bryan B Bouton

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

X Inter

23B. DATE SIGNED

12-26-65

23C. PHYSICIAN'S
NAME (Type)

BRIAN B BOUTON

M.D.

23D. ADDRESS

4940 Eastern Ave., Baltimore, Md., #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-29-1965

24C. NAME OF CEMETERY or CREMATORY

Fork Methodist Cemetery

24D. LOCATION

Fork,

(City, town, or county)

Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1965

25B. NAME OF REGISTRAR

Robert E. Feltus

25C. FUNERAL DIRECTOR

Langan Funeral Home 740 Belair Road

ADDRESS

36

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

letter/10/11/11 from hospital . C. B.

then 5 empty drums put in

the above A/C to 1, 1, 1
— and 500

Drum & Gunter

GRAND & GORDON

GRH

X 100

11-10 12

11-10 12

11-10 12

11-10 12

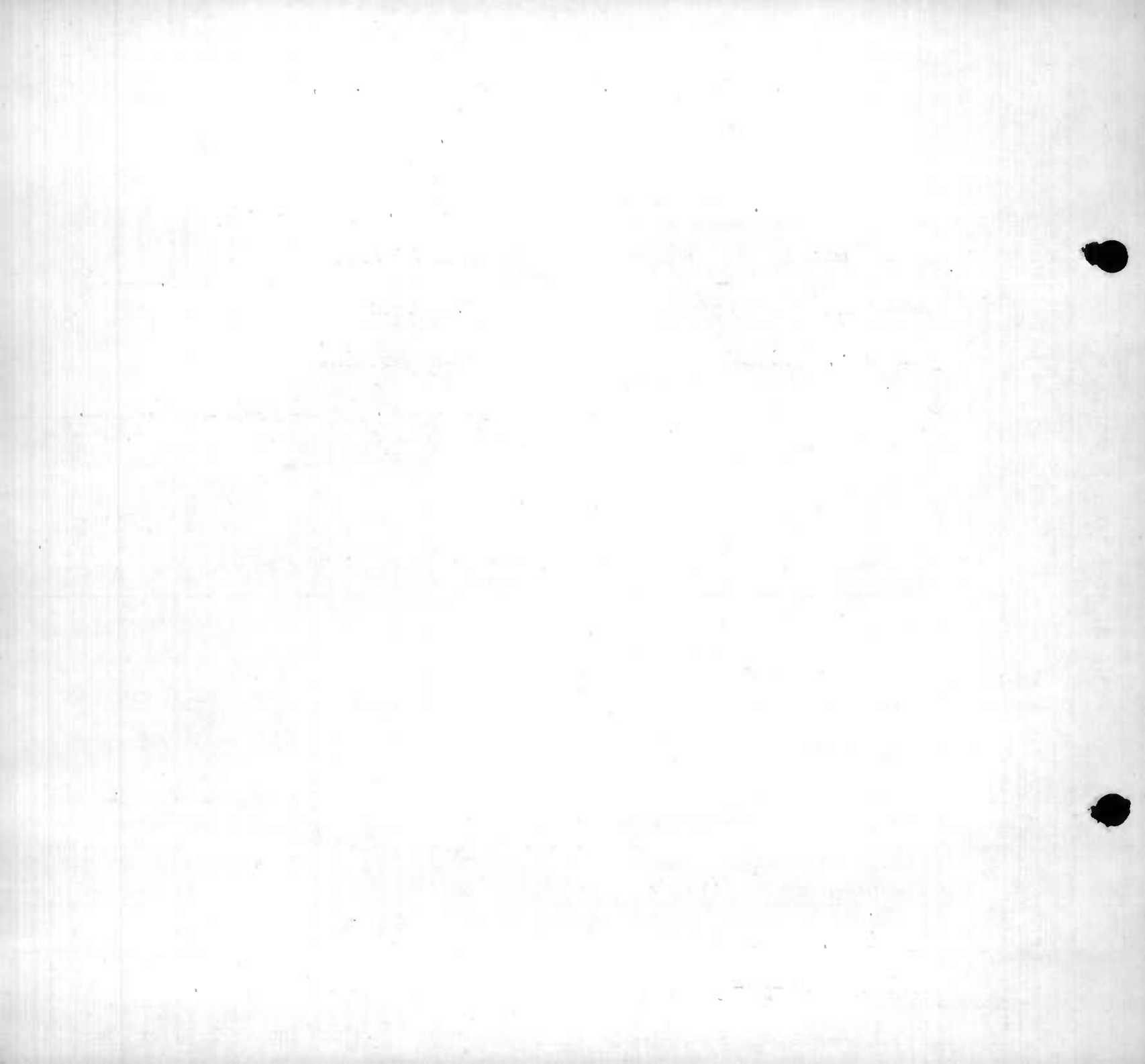
11-10 12

11-10 12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

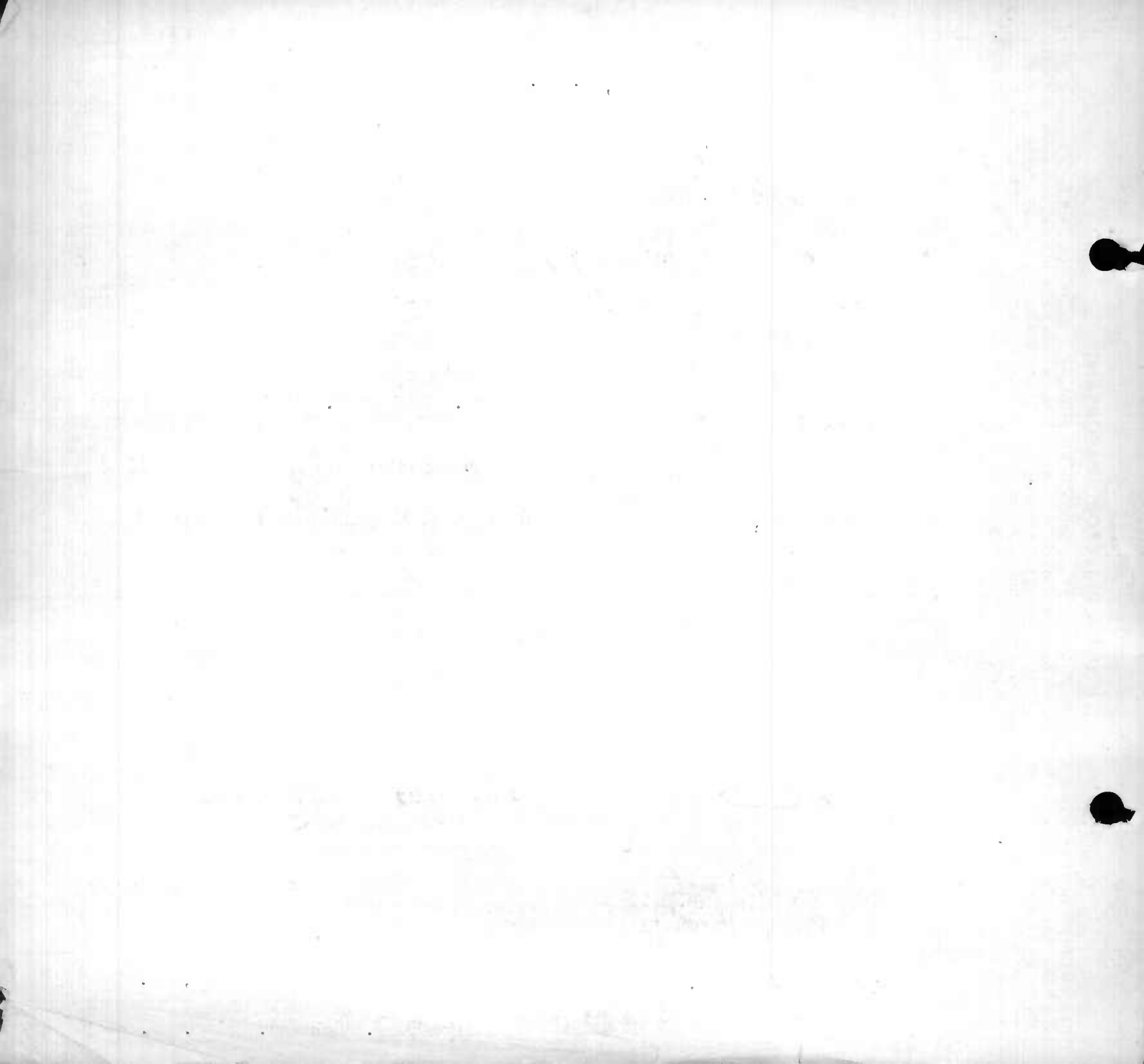
| BIRTH NO. 65 13355 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13355 | |
|--|------------------|---|------------------------------------|---|---|---|-------------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mrs. Elizabeth J. Vogel | | | | 2. DATE AND HOUR OF DEATH Dec. 27, 1965 9 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1815 E. 29th Street | | | | A. STATE Md. 9-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1815 E. 29th Street | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH April 10, 1888 | 9. AGE (In years last birthday) 77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME George A. Zeiler | | | | 14. MOTHER'S MAIDEN NAME Mary Schmidt | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT George A. Vogel 5907 Falkirk Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I CORONARY OCCLUSION HYPERTENSIVE CARDIO- VASCULAR DISEASE CORONARY SCLEROSIS | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH INSTANT 5 years 5 years | |
| 19. DATE OF OPERATION D | | | | 20. AUTOPSY? (Yes or No) | | 21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 1 1937 to DECEMBER 26 1965, that (I) (we) last saw the deceased alive on DECEMBER 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Erwin E. Mayer | | | | 23B. DATE SIGNED 12/27/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Erwin E. Mayer | | | | 23D. ADDRESS 2525 EUTAW PLACE THE ESPLANADE BPTS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12-30-65 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Falkenberg | | 25C. FUNERAL DIRECTOR Leonard J. Mack Inc | | 25D. ADDRESS 5305 Harford Road "14 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13356 | |
|--|--------------|---|-----------------------------|---|--|
| BIRTH NO. 65 13356 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Williams, Henry, D. Sr. | | 2. DATE AND HOUR OF DEATH 12/28/65 1:30 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY BALTIMORE MD 27-19 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2712 NORTHERN PARKWAY 21214 | | D. STREET ADDRESS (If rural, give location) | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7/30/02 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Detective | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME DAVID WILLIAMS | | 14. MOTHER'S MAIDEN NAME ANNA FRITZ | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Elfrieda C. Williams | |
| ADDRESS (Same) | | | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) Arteriosclerotic cardiovascular disease DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 16 hrs 1 year | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity - exogenous | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from 8 am 12/28 1965 to 1:30 am 12/28 1965, that (we) last saw the deceased alive on 12/28/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Philip Horowitz | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) Philip Horowitz | | 23D. ADDRESS M.D. 601 N BROADWAY 21205 | | THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR Leonard J. Rack Inc. Balto. Md. 21214 | | 25D. ADDRESS | | | |



| 65 13357 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13357 | |
|---|--|--|--|---|---|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) CECIL S. LOGUE | | | 2. DATE AND HOUR PRONOUNCED DEAD December 28, 1965 9:50 A. ^{M.} | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1627 Aliceanna Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Sept. 18, 1917 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY Garage | 11. BIRTHPLACE (State or foreign country) Berkeley County, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Charles Logue | | | 14. MOTHER'S MAIDEN NAME Luella Starliper | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 232-26-5891 | 17. INFORMANT ADDRESS Mrs. George (Mary Jane) Price-Martinsburg, W. Va. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I Arteriosclerotic cardiovascular disease DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner W. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12-28-65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE 12-31-65 | 23C. NAME of CEMETERY or CREMATORY Hedgesville Cemetery | 23D. LOCATION (City, town, or county) (State) Hedgesville, Berkeley, W. Va. | | |
| 24A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | 24C. FUNERAL DIRECTOR Brown Funeral Home | | ADDRESS Martinsburg, W. Va. | |

VALLEY FORGE

RECEIVED

Handwritten signature or initials at the bottom left of the page.

BIRTH NO.

65 13358

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 13358

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

SAMUEL FARACE

2. DATE AND HOUR PRONOUNCED DEAD

26 December 1965 9:25 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

8011 Dalesford Rd.

5. SEX

male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widower

8. DATE OF BIRTH

March 3, 1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

9 23

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Market Attendant

11. BIRTHPLACE (State or foreign country)

Mississippi

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Cosimo Farace

14. MOTHER'S MAIDEN NAME

Concetta Fertitta

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-05-9308

17. INFORMANT

ADDRESS

James Farace 39 S. Fulton Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/26/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/29/65

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 30 1965

24B. NAME OF REGISTRAR

Robert S. Farace, M.D.

24C. FUNERAL DIRECTOR

Fred. B. Cole, 1913 W. Balto. St.

ADDRESS

Balto., Md.

WILHELM FORGIE

ACCOUNT

1884

1885

1886

1887

1888

1889

1890

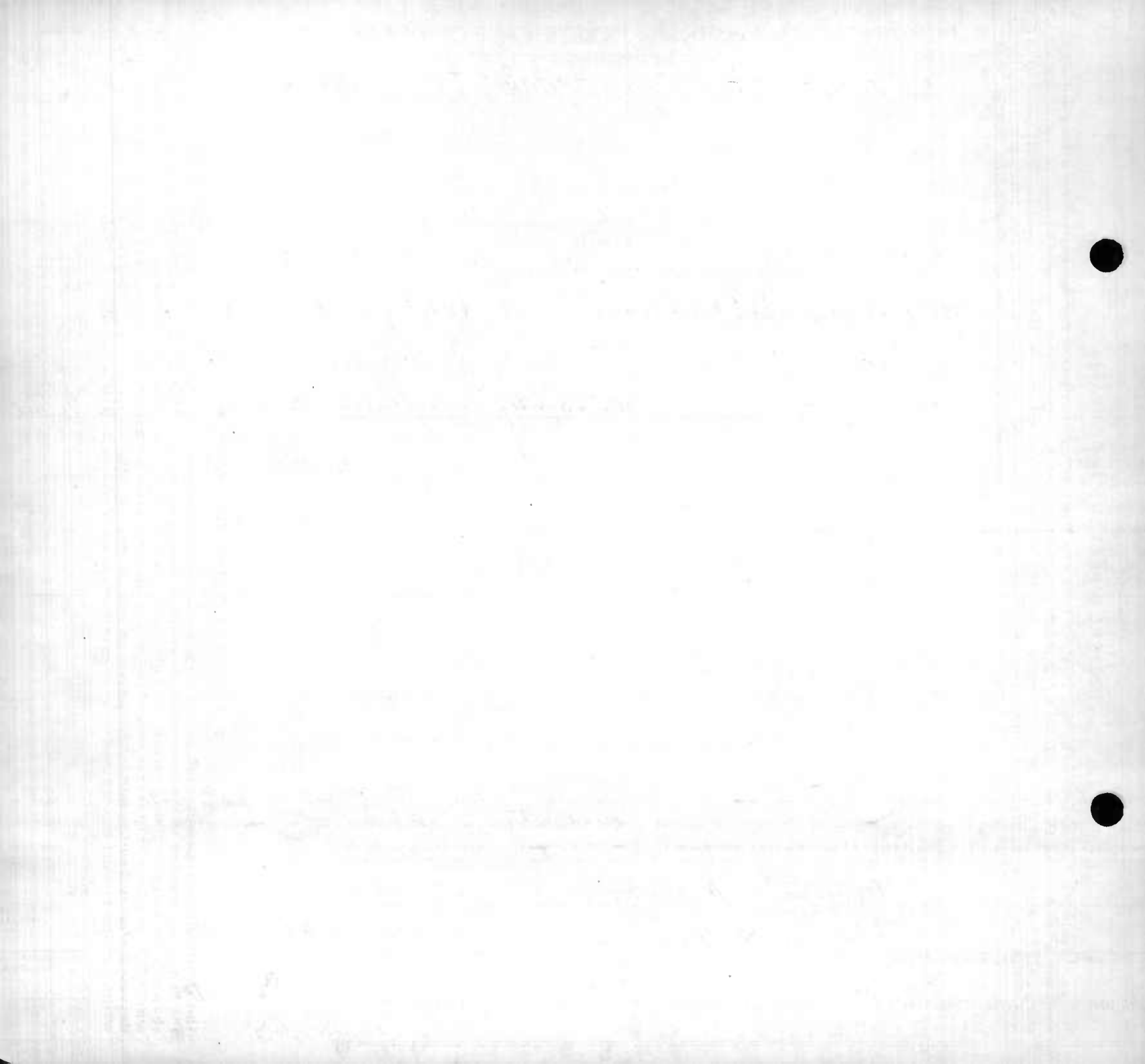
1891

1892

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13359 | |
|--|---|--|---|---|--|
| BIRTH NO. 65 13359 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WADE HAMPTON HAMMETT | | 2. DATE AND HOUR OF DEATH Dec. 27-1965 7 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3911 SECOND ST BROOKLYN | | A. STATE Maryland B. COUNTY 25-04 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 4103 Orchard Ave | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH March 24, 1883 | 9. AGE (In years last birthday) 82 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Yard foreman B & O Railroad | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Westminster Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME James Hammett | | 14. MOTHER'S MAIDEN NAME Missouri Little | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 705-05-6219 | | 17. INFORMANT Mrs. Ruth Garvey | |
| 18. 420.1 I | | CAUSE OF DEATH | | ADDRESS 4103 Orchard Ave Baltimore Md. | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | (A) Coronary Thrombosis DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 hr? | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Arterio-sclerotic Heart Disease DUE TO | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (1) (this hospital) attended the deceased from May 1965 to Dec. 27 1965, that (1) (we) last saw the deceased alive on Dec. 27 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Vincent M. Messina | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) Vincent M. Messina | | M.D. 23D. ADDRESS 1403 S. Charles St Balto 21230 Md | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/30/65 | | 24C. NAME OF CEMETERY or CREMATORY Kuders Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Rural, Westminster Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR R. E. Farkas | |
| 25C. FUNERAL DIRECTOR J. S. Myers, Jr. | | ADDRESS Westminster Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13360 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13360 | |
|--|--|---|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Kristine) THELMA KRISTINE SCHMIDT | | 2. DATE AND HOUR OF DEATH DECEMBER 27, 1965, 7:50P | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| ST. AGNES HOSPITAL | | | | BALTIMORE | | D. STREET ADDRESS (If rural, give location) | |
| 634 DOUGLAS STREET | | | | 5. SEX FEMALE | | 6. RACE WHITE | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | | | 8. DATE OF BIRTH 11-14-05 | | 9. AGE (In years last birthday) 60 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | | | 10B. KIND OF BUSINESS OR INDUSTRY WESTERN AUTO | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U S | | | | 13. FATHER'S NAME FRANCIS ORRELL | | | |
| 14. MOTHER'S MAIDEN NAME NANNIE HERLEY | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 212 10 4289 | | | | 17. INFORMANT Mrs. Edna T. Smith AVENUE (Same as address) ST. AGNES HOSPITAL WILKENS AND CATON | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | MULTIPLE intestinal adhesions & fistulas | | | |
| ANTECEDENT CAUSES | | | | (A) DUE TO Pneumonia | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | | | (B) DUE TO Colostomy infection because of the uterus | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Terminal pneumonia | | | |
| 19A. DATE OF OPERATION 12-17-65 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (IX) (this hospital) attended the deceased from NOVEMBER 10 19 65 to DECEMBER 27 19 65, that (I) (we) lost saw the deceased alive on DECEMBER 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) OCTAVIO DE MARCHENA | | | | 23D. ADDRESS ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 30/65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem. | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Farkas | | 25C. FUNERAL DIRECTOR R. K. Singleton | | ADDRESS Glen Burnie, Md. | |

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Handwritten text at the bottom of the page, possibly a date or a reference number.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13361 | |
|---|--------------------------------|--|--|---|---|
| BIRTH NO. 65 13361 | | CERTIFICATE OF DEATH | | Registered No. 65 13361 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Margaret A. Moog</i> | | 2. DATE AND HOUR OF DEATH <i>December 26, 1965 7:30 p.m.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Anne Arundel</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Severna Park 5200</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>House - In - The Pines Nursing Home #2525 W. Belvedere Ave.</i> | | D. STREET ADDRESS (If rural, give location) <i>Old Annapolis Road</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>Oct. 19, 1887</i> | 9. AGE (In years last birthday) <i>84</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife (ret.)</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Unknown (Barker)</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT <i>Mrs. Eva Moog (sister-in-law)</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>442X I</i> | | CAUSE OF DEATH (A) DUE TO <i>uremia</i> <i>Arterio Sclerosis Cardio Vascular</i> (B) DUE TO <i>Renal Failure</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>2da</i> <i>syn</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/16</i> 19 <i>65</i> to <i>12/26</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/26/65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Joseph E. Laukaitis MD</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <i>12/28/1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOSEPH E. LAUKAITIS MD</i> M.D. | | 23D. ADDRESS <i>679 Washington Blvd Baltimore</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>Dec. 29/65</i> | 24C. NAME OF CEMETERY or CREMATORY <i>Western Cem</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>R. V. Singletary</i> ADDRESS <i>Glen Burnie, Md.</i> | |

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13362 | |
|---|------------------|---|-----------------------------------|--|--|
| BIRTH NO. 65 13362 | | CERTIFICATE OF DEATH | | Registered No. 65 13362 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Tracy H. Leimbach | | 2. DATE AND HOUR OF DEATH Dec. 27, 1965 8:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Nursing Home | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 23-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 119 W. Ostend St. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Nov. 19, 1878 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. City | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Herman Leimbach | | 14. MOTHER'S MAIDEN NAME Theresa Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Julia B. Leimbach 119 W. Ostend St. | |
| 18. 490 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) bilateral pneumonia DUE TO several weeks. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. bilateral pneumonia DUE TO several weeks | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. atrial fibrillation | | | | several weeks | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 10, 19 65 to 12/27/65, 19 65, that (I) (we) last saw the deceased alive on 12/27/65, 19 65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. Ellsworth Cook M.D. | | | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook | | 23D. ADDRESS M.D. 2431 Maryland Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12 31 1965 | | 24C. NAME of CEMETERY or CREMATORY Parkwood | |
| 24D. LOCATION Balto. Md. | | 24E. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | | |
| 24F. NAME OF REGISTRAR Robert E. Talley | | 24G. FUNERAL DIRECTOR McGulley | | 24H. ADDRESS 130 E. Fort Ave | |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---|---------|---|------------------|---|--|--|--|
| 65 13363 | | | | | | 65 13363 | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| BROOKS C. DOUGLAS | | | | December 29, 1965 12:28 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospital | | | | Maryland Baltimore | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore - Edgemere | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 2525 S. Snyder Avenue 21219 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. | | |
| male | white | Separated | Nov. 10-1912 | 53 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Piperitter | | Bethlehem Steel Co. | | West Virginia | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Sheridan C. Douglas | | | | Nancy J. Bailey | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No None | | 232-05-7164 | | Mrs. Claudine Riptrap, # 4,a,b,c,d. | | | |
| 18. CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | |
| (A) Arteriosclerotic cardiovascular disease | | | | | | | |
| DUE TO | | | | | | | |
| (B) DUE TO | | | | | | | |
| (C) DUE TO | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | no | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | Rudiger Breitenecker, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 12-29-65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | Dec. 31-1965 | | Oak Lawn | | 7225 Eastern Ave. Balto. Md. 21224 | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | | | |
| DEC 30 1965 | | John J. Duda | | John J. Duda 7922 Wise Ave. Dundalk, Md. | | | |

10/10/1911

FUNERAL DIRECTOR: IMPORTANT

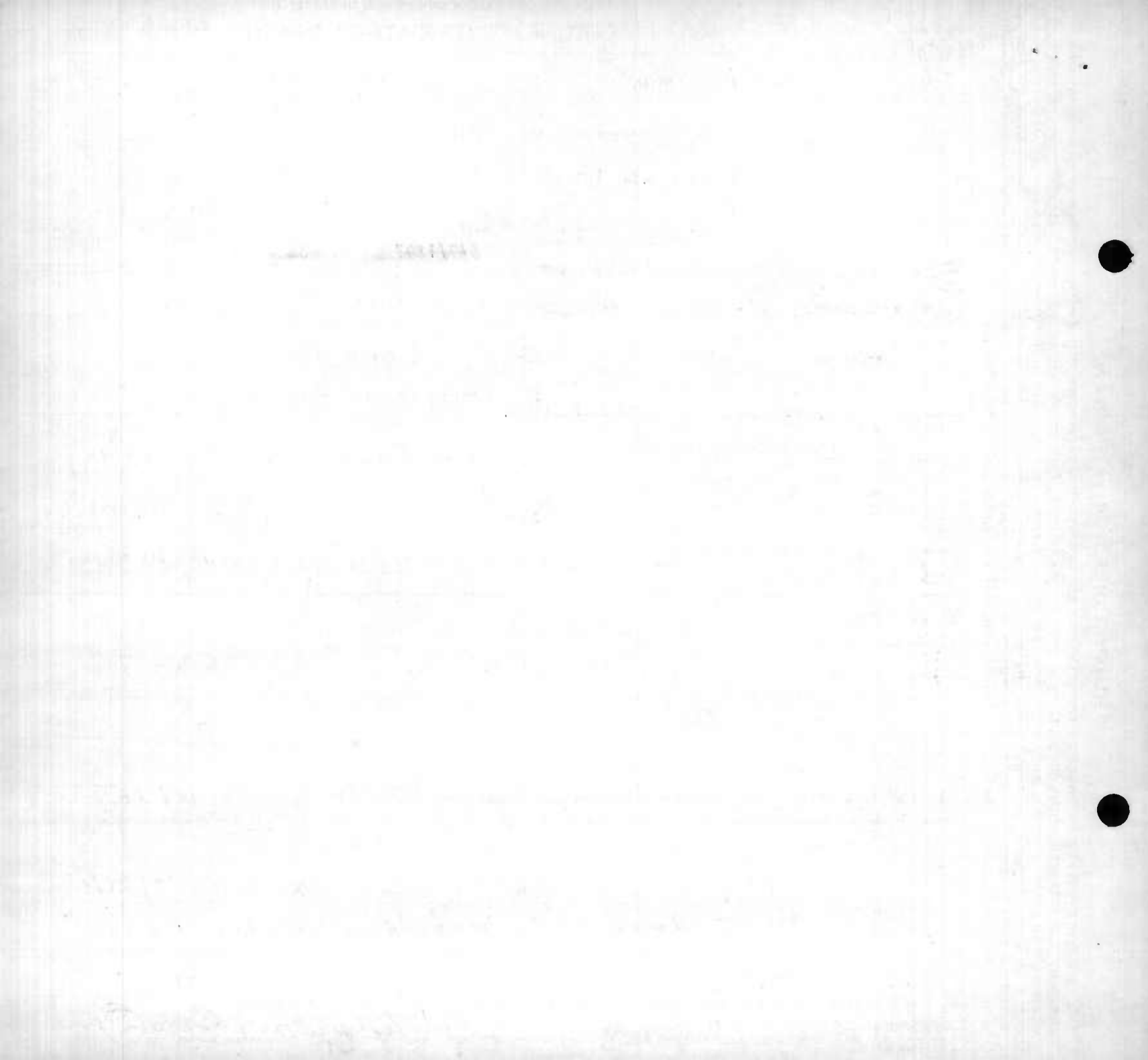
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|--|--|------------------------------------|
| BIRTH NO. 65 13364 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13364 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MOSKOWITZ, MAX | | 2. DATE AND HOUR OF DEATH 12-25-65 10 ¹⁵ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #15 D. STREET ADDRESS (If rural, give location) 5101 Queensberry Ave | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp of Baltimore | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 12-25-65 | 9. AGE (In years last birthday) 63 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Salesman | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Morris Moskowitz | | 14. MOTHER'S MAIDEN NAME Ethel - ? | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI Army | | 16. SOCIAL SECURITY NO. yes | | 17. INFORMANT Harry M. WALLEN, MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia | | CAUSE OF DEATH (A) DUE TO Acute Myocardial Infarct Immediate (B) DUE TO ASCVD (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH Over 10 years | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? None | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-19-65 to 12-25-65, that (I) (we) last saw the deceased alive on 12-25-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry M. Wallen | | | | 23B. DATE SIGNED 12-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY M. WALLEN | | | | 23D. ADDRESS 5356 Carriage Court Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/26/65 | | 24C. NAME OF CEMETERY or CREMATORY Plesnia Cong | |
| 24D. LOCATION Rosedale, Md. | | 24E. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 24F. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 24G. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 24H. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 24I. FUNERAL DIRECTOR Sol Sherman & Bros 6010 Kent, Rd. | |

FUNERAL DIRECTOR: IMPORTANT

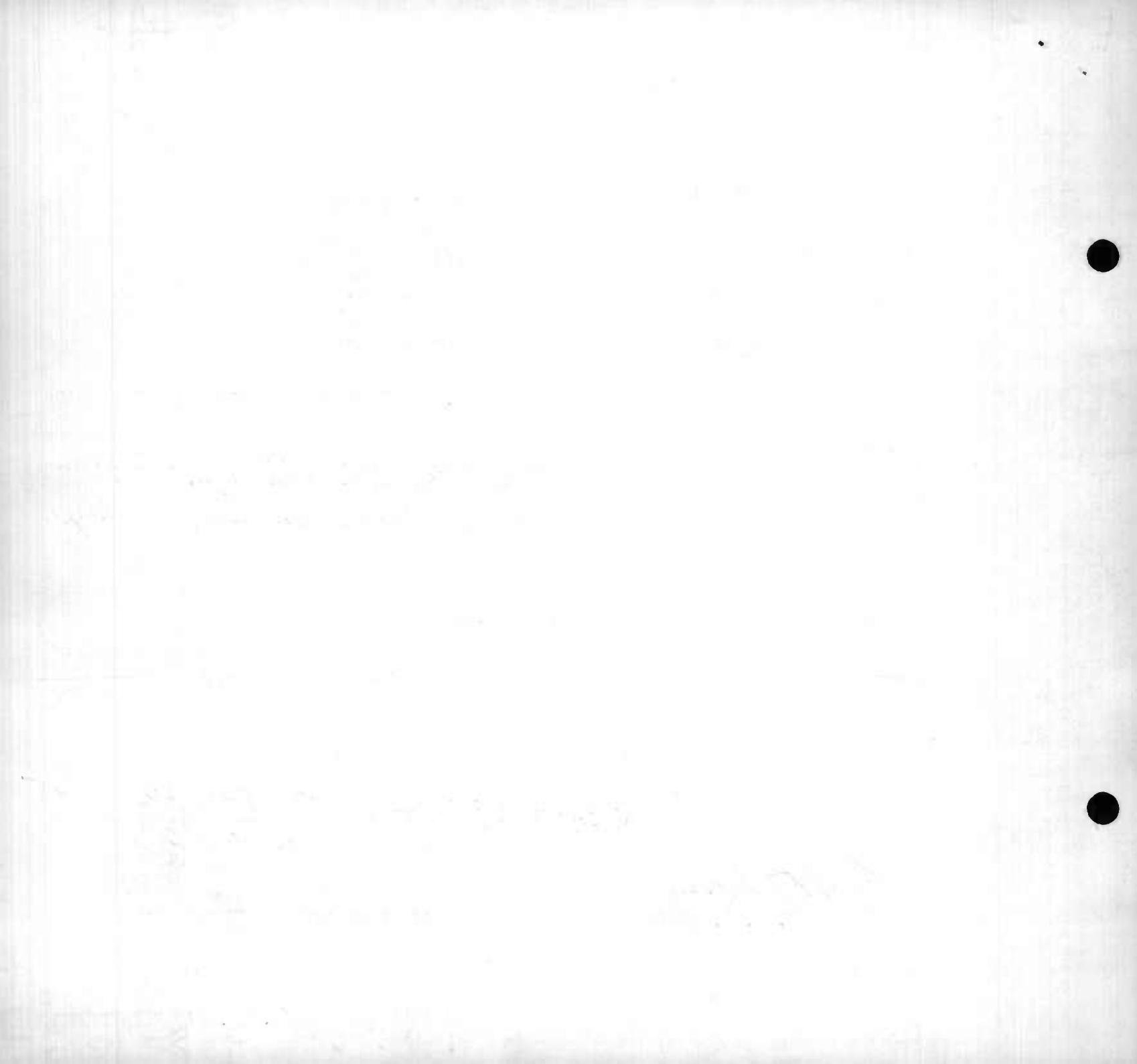
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|---|---|---|
| BIRTH NO. 65 13365 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13365 | |
| 1. NAME OF DECEASED (Type or Print) Mrs. ANNETTE F. NEWMAN | | | 2. DATE AND HOUR OF DEATH 12/26/65 7:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL; BALTO. MD. 21231 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15 D. STREET ADDRESS (If rural, give location) 5209 WILTON HEIGHTS AVE | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 6/9/1897 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) NEW YORK | |
| 13. FATHER'S NAME JACOB FEILEPBERG | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 217-16-4937 | | |
| 17. INFORMANT MARVIN NEWMAN | | | ADDRESS 7426 RICKSWAY ROAD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 154 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Cardiac failure | | | CAUSE OF DEATH (A) INTESTINAL OBSTRUCTION DUE TO (B) Carcinoma Recto Sigmoid & DUE TO (C) Metastasis in Peritonium & small bowel | | |
| INTERVAL BETWEEN ONSET AND DEATH 19 days | | | INTERVAL BETWEEN ONSET AND DEATH 13 months | | |
| INTERVAL BETWEEN ONSET AND DEATH Unknown | | | INTERVAL BETWEEN ONSET AND DEATH 15 minutes | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 12/23/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/10/65 to 12/26/1965 , that (I) (we) last saw the deceased alive on 12/26/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Rosin | | | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. J. ROSIN | | 23D. ADDRESS 3302 STRATHMORE AVE BALTO. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12/27/65 | 24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON) | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | 25B. NAME OF REGISTRAR Robert E. Johnson | 25C. FUNERAL DIRECTOR John Johnson & Bros | | ADDRESS REISTERSTOWN RD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13366 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13366 | |
|--|------------------|---|------------------------------|---|----------------------------|--|-----------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) JACOB FOREMAN | | | | 2. DATE AND HOUR OF DEATH DECEMBER 27, 1965 12:03 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-20 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3703 FALLSTAFF ROAD | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8/2/1900 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER | | 10B. KIND OF BUSINESS OR INDUSTRY TAVERN | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME JOSEPH FOREMAN | | | | 14. MOTHER'S MAIDEN NAME HINDA GRAZINSKY | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. MINNIE FOREMAN | | | | ADDRESS 3703 FALLSTAFF ROAD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 420.1 I ARTERIOSCLEROSIS WITH HYPERTENSION (CORONARY DISEASE) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO ARTERIOSCLEROSIS WITH HYPERTENSION (CORONARY DISEASE) CORONARY OCCLUSIVE DISEASE INTERVAL BETWEEN ONSET AND DEATH 2 years 5 days | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 28, 1945 to Dec 26, 1965. that (I) (we) last saw the deceased alive on December 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Dec 26 / 65 | | | | | | | | | |
| 23A. SIGNATURE M.B. Levin | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/27/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. M. B. LEVIN | | | | 23D. ADDRESS M.D. 218 EAST UNIVERSITY PARKWAY | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/28/65 | | 24C. NAME of CEMETERY or CREMATORY AN SHE EMUNAH AITZ CHAIM | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Sol Levinson | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. | | ADDRESS 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. M.E. CASE NO. | | BALTIMORE CITY HEALTH DEPARTMENT 65 13367 | | CERTIFICATE OF DEATH | | Registered No. 65 13367 | |
|---|-----------------------------|--|---|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) John (or) Jan Melnychuk | | | | 2. DATE AND HOUR OF DEATH Dec 29 1965 5:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 929 N. Maderia St. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 929 N Maderia St. | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 4, 1911 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10B. KIND OF BUSINESS OR INDUSTRY Dryer Box Co. | | 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? 1st papers: | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-30-2394 | | 17. INFORMANT Mary Melnychuk 929 N. Maderia St. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cancer of Lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH 3 months | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 17 1965 to Dec 29 1965 , that (I) (we) last saw the deceased alive on Dec 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Albert Sikorsky | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) Albert Sikorsky | | | | 23D. ADDRESS M.D. 2939 McEldery St Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Jan 1 1965 | | 24C. NAME OF CEMETERY or CREMATORY Holy Trinity Cem | | 24D. LOCATION (City, town, or county) (State) Elkridge, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Tabor | | 25C. FUNERAL DIRECTOR Dippel Brothers Inc. 1800 E. Lombard St. | | | |

Handwritten signature

~~*Handwritten signature*~~

W. H. H. H.

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13368 | |
|--|------------------------------|--|--|--|---|
| BIRTH NO. 65 13368 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EDITH RIBACK | | 2. DATE AND HOUR OF DEATH 12-28-65 12:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY USA | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME + HOSPITAL BALTIMORE, Md. 21231 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 1721 E. BALTIMORE ST | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH - | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME MORRIS GROSS FELD | | | 14. MOTHER'S MAIDEN NAME ITIRIAM ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MR. HARRY RIBACK 1721 E BALTIMORE ST | |
| 18. 331X + 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cerebrovascular accident DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 12 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Adenocarcinoma colon | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) - | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-16 19 65 to 12-28 19 65 , that (I) (we) last saw the deceased alive on 12-28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Mariano | | | | 23B. DATE SIGNED 12-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) IDILIA C. MARIANO | | 23D. ADDRESS CHURCH HOME + HOSPITAL BALTIMORE, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 12/29/65 | 24C. NAME OF CEMETERY or CREMATORY RUDOMER VEREIN | | 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |

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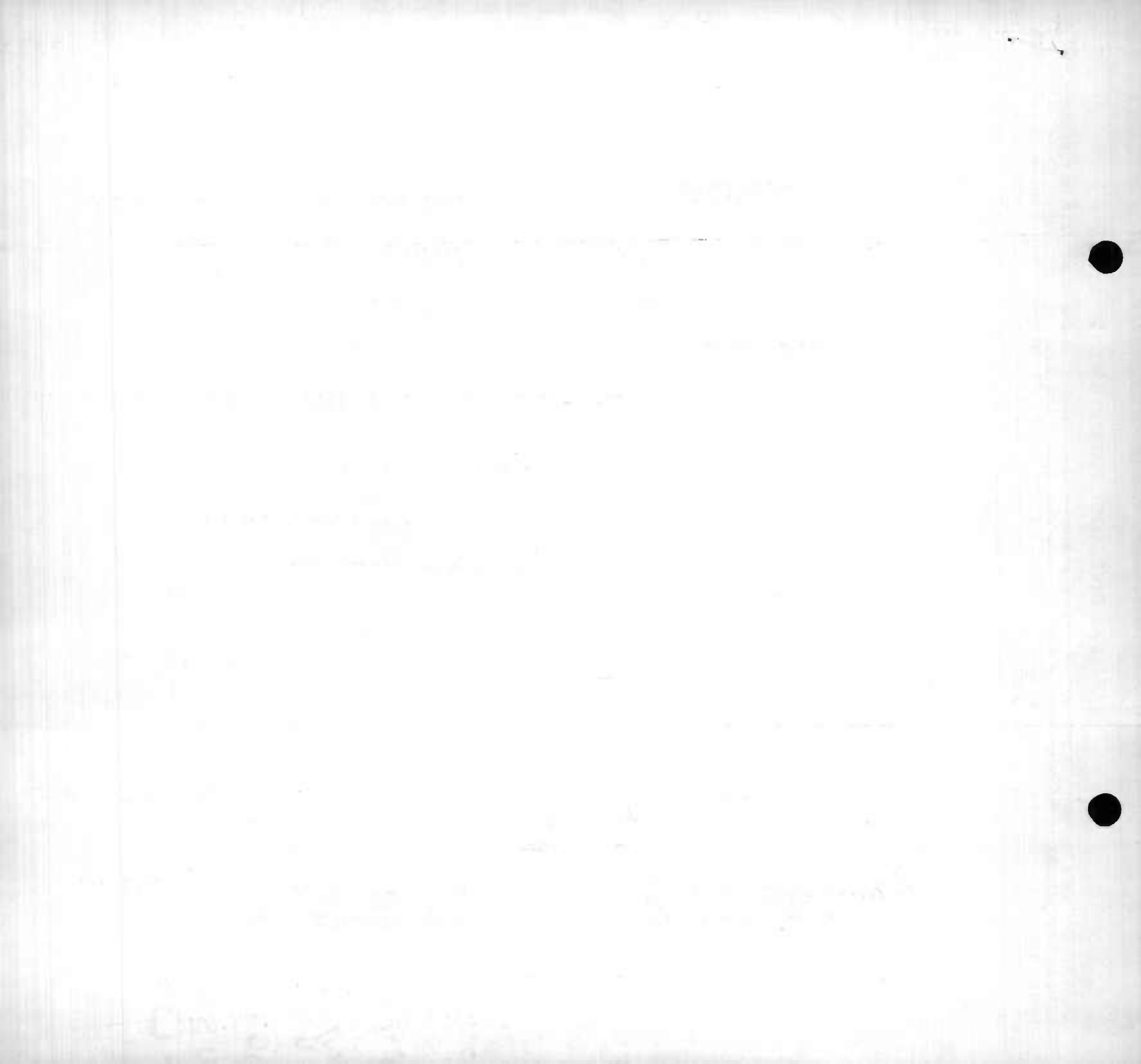
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13369 | | CERTIFICATE OF DEATH | | Registered No. 65 13369 | |
|--|-------------------------|--|--------------------------------------|---|----------------------------|--|-----------------------------|-------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) ROSE M. MILLER | | | | 2. DATE AND HOUR OF DEATH DECEMBER 27, 1965 8:20 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5902 CROSS COUNTRY BOULEVARD APT C | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-20 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5902 CROSS COUNTRY BOULEVARD APT C | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 2/23/1884 | 9. AGE (In years lost birthday) 81 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) LITHUANIA | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME BENJAMIN CRAMER | | | | 14. MOTHER'S MAIDEN NAME VENTA GOLD | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217-18-1968 | | 17. INFORMANT ADDRESS MISS SYLVIA MILLER 5902 CROSS COUNTRY BLVD | | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <i>Consumption</i> DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (B) <i>Hypertension Cardiac Vascular Disease</i> DUE TO | | | | | |
| | | | | (C) <i>Generalized Atherosclerosis</i> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June</i> 19 <i>57</i> to <i>Dec 26</i> , 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Dec 26</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Daniel Schwartz</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 12/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. DANIEL SCHWARTZ | | | | 23D. ADDRESS M.D. 4000 W NORTHERN PARKWAY | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/28/65 | | 24C. NAME of CEMETERY or CREMATORY HEBREW FRIENDSHIP | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Feltman</i> | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. 65 13370 | |
|--|-----------|--|---|---|--|--|-----------------------------------|
| BIRTH NO. 65 13370 | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 65 13370 | | | | 1. NAME OF DECEASED (Type or Print) Waara, Lydia LYDIA WAARA | | | |
| 2. DATE AND HOUR OF DEATH Dec 28 1965 7:50 P.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital Balto. 1, Md. | | | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-05 D. STREET ADDRESS (If rural, give location) 706 Rappola St. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 4/14/98 | 9. AGE (In years last birthday) 67 | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Finland | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME ? Unknown Matti Ratanen M.D. | | | 14. MOTHER'S MAIDEN NAME ? Unknown Louisa Kolenanen | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NUMBER NONE | | 17. INFORMANT ADDRESS Mrs. Oliver L. Waara 6809 Bank Street | | |
| 18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH Broncho pneumonia Cerebral edema Hypokalemia Diabetes Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Subdural hematoma | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald T. Lewers M.D. | | | | 23B. DATE SIGNED 12/28/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) DONALD T. LEWERS | | | | 23D. ADDRESS MARYLAND GENERAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Henry Sander & Sons Inc. | | ADDRESS Baltimore Maryland 21213 | |

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F. W. W.

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Baltimore, Md.
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--------------|--|---|---|---|
| BIRTH NO. 65 13371 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 13371 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Schwartz, PHILLIP (Philip Schwartz) | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 2. DATE AND HOUR OF DEATH 12-28-65 8 AM M. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3204 HAYWARD AVE. #15 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 12-20-92 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Guard | | 10B. KIND OF BUSINESS OR INDUSTRY Horse Race Track | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | |
| 13. FATHER'S NAME William Schwartz | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 14. MOTHER'S MAIDEN NAME Margaret Adams | | |
| 16. SOCIAL SECURITY NO. 215-05-4540 | | | 17. INFORMANT Hosp. Rec. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SUBDURAL HEMORRHAGE, RIGHT INTERVAL BETWEEN ONSET AND DEATH 60 HRS | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PSH CVD | | | | | |
| 19A. DATE OF OPERATION 12-25-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SUBDURAL HEMATOMA | | 20A. AUTOPSY (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Yes | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3204 HAYWARD AVE. #15 27-17 | |
| 21D. TIME OF INJURY (APPROX.) 4 PM 12-25-65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? FELL FROM STEPS | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-25-65 19 to 12-28-65 19, that (I) (we) last saw the deceased alive on 12-28-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles L. Pio Roda | | | 23B. DATE SIGNED 12-28-65 | | |
| 23C. PHYSICIAN'S NAME (Type) CHARLES L. PIO RODA | | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY Lake View Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Liberty Road Carroll County, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | | |
| 25B. NAME OF REGISTRAR R. L. E. Fairley | | 25C. FUNERAL DIRECTOR J. Vernon Lemmon | | | |
| 25D. ADDRESS 4611 Park Heights Ave. | | | | | |

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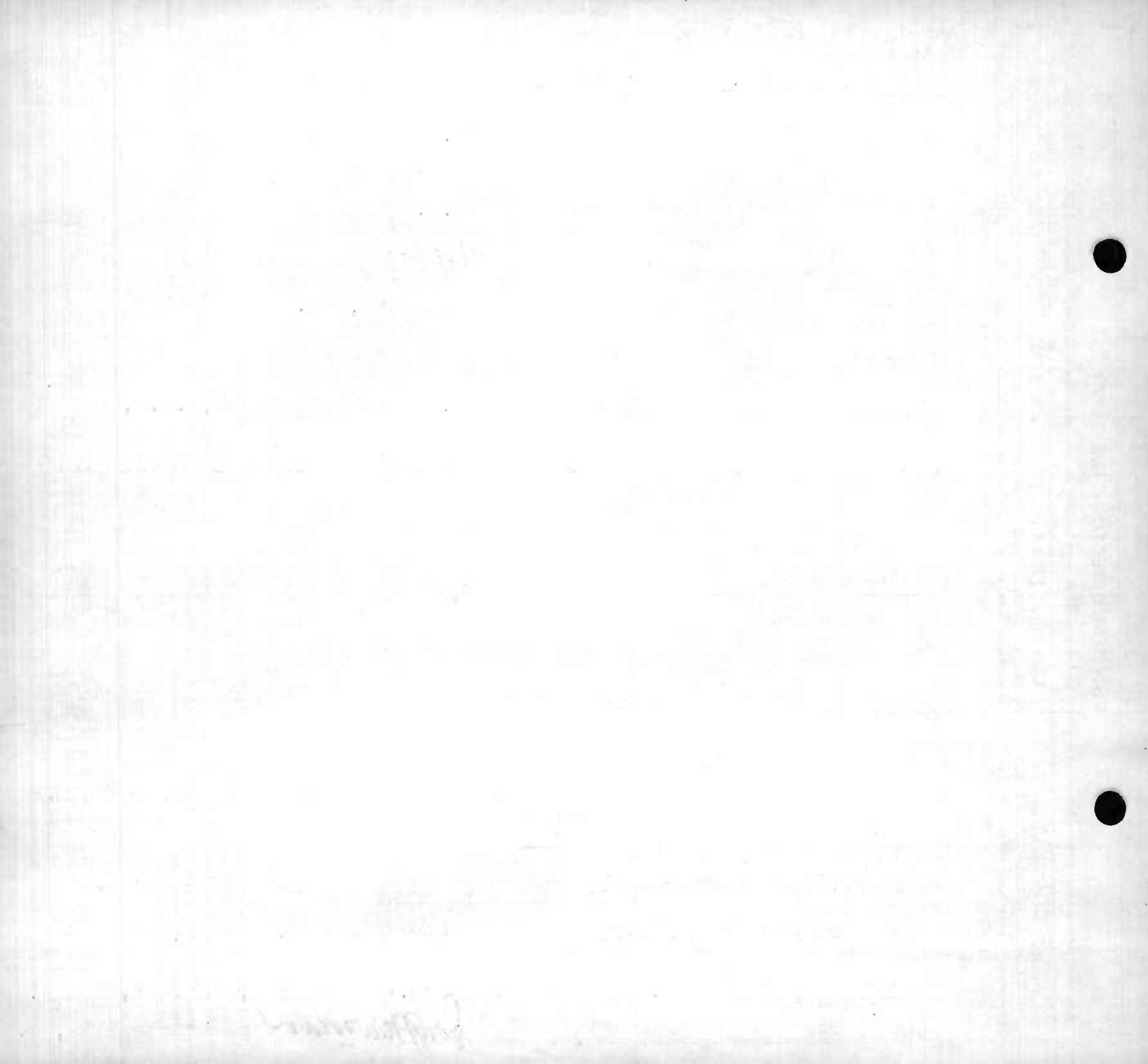
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FUNERAL DIRECTOR: IMPORTANT

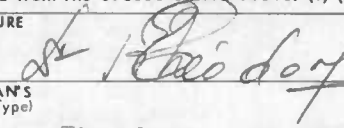
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

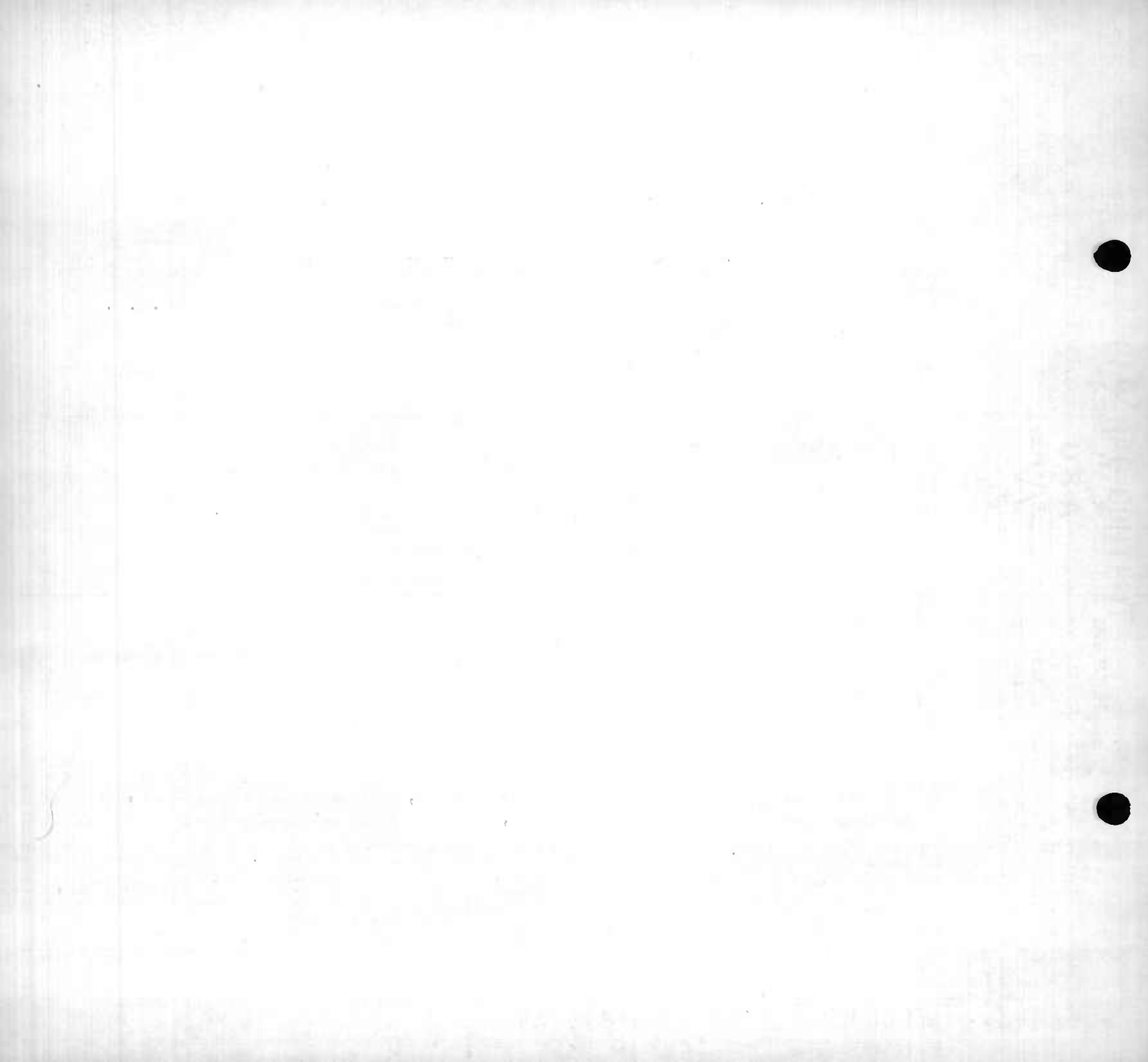
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|-------------------------------------|--|--|
| BIRTH NO. 65 13372 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 13372 | | | | |
| 1. NAME OF DECEASED (Type or Print) CLARENCE A. RINGER | | | | | 2. DATE AND HOUR OF DEATH DEC. 26, 1965 6:00 P.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE, MARYLAND - 21201 | | | | | A. STATE Md. B. COUNTY Garrett | | | | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Grantsville (Rural) 61-20 | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) R.D. #1 | | | | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | | 8. DATE OF BIRTH 4/28/90 | | 9. AGE (In years lost birthday) 75 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | | | | 10B. KIND OF BUSINESS OR INDUSTRY Own Farm | | | | | 11. BIRTHPLACE (State or foreign country) Listonburg, Pa. | | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | 13. FATHER'S NAME Jeremiah Ringer | | | | | 14. MOTHER'S MAIDEN NAME Emma Cramer | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 212-38-5894 | | | | | 17. INFORMANT ADDRESS Md. | | | | |
| 18. 053.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | | | (A) SEPTIC SHOCK, SOURCE UNDETERMINED DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | | | | | | |
| (C) DUE TO | | | | | | | | | | | | | | |
| II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/22 19 65 to 12/26 19 65 , that (I) (we) last saw the deceased alive on 12/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Martin C. Shargel | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/26/65 | | |
| 23C. PHYSICIAN'S NAME (Type) MARTIN C. SHARGEL | | | | | | | | | | 23D. ADDRESS UNIVERSITY HOSPITAL, BALTO., MD - 21201 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/29/65 | | 24C. NAME of CEMETERY or CREMATORY St. Pauls Lutheran Cem. | | 24D. LOCATION (City, town, or county) (State) Fort Hill, Somerset, Penna. | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR Longfellow | | ADDRESS Grantsville, Md. | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13373 | |
|---|--------------------------------|--|---|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 13373 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Roland Waters (Norman) | | | 2. DATE AND HOUR OF DEATH December 28, 1965 6:25 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-54 5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6. STREET ADDRESS (If rural, give location) 1806 Walbrook Avenue | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 12-19-1892 | 9. AGE (In years last birthday) 73 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME William Henry Waters | | | 14. MOTHER'S MAIDEN NAME Mary Finley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 317-22-3345 | 17. INFORMANT Vernell Johnson | | |
| 18. CAUSE OF DEATH 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE CEREBRAL HEMORRHAGE HYPERTENSIVE HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 19. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 28, 1965 to December 28, 1965 , that (I) (we) last saw the deceased alive on December 28, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | 23B. DATE SIGNED December 29, 1965 | | 23C. PHYSICIAN'S NAME (Type) Roger Theodore |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-31-65 | | 24C. NAME OF CEMETERY or CREMATORY mt Auburn Cem | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR George A. Miller | | | |
| 25D. ADDRESS 1514 Division Street | | 25E. ADDRESS 1348 N. Calhoun St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|----------------------|--|--|---|--|---|--|-------------------------------------|--|--|---|--|--|--|--|--|
| BIRTH NO. 65 13374 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 13374 | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Juanita (Wm) Jenkins | | | | | | | | | | 2. DATE AND HOUR OF DEATH 12/28/65 825 A.M. | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1205 301 E. Lanvale Street | | | | | | | | | | |
| 5. SEX F | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH 3-16-41 | | 9. AGE (In years last birthday) 24 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N. Carolina | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | |
| 13. FATHER'S NAME John S. Johnson | | | | | | | | | | 14. MOTHER'S MAIDEN NAME Novella Jenkins | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mother | | | | ADDRESS 401 E 20th St Balt 18 | | | | | | | | | | |
| 18. 5-8-101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hemorrhage from Peptic Ulcer ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe cirrhosis | | | | | | | | | | CAUSE OF DEATH (A) Hemorrhage from Peptic Ulcer DUE TO (B) Severe cirrhosis DUE TO (C) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemorrhagic pancreatitis Hemorrhagic Duodenitis, poss bleeding disorder | | | | | | | | | | 19A. DATE OF OPERATION 12/27/65 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Upper G. I. bleeding | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from 12/27/65 19 to 12/28/65 19, that (I) (<u>we</u>) last saw the deceased alive on 12/28/65 19 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Richard R. Stephenson | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/28/65 | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. RICHARD R. STEPHENSON | | | | | | | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-1-66 | | 24C. NAME OF CEMETERY or CREMATORY Church Cem. | | | | 24D. LOCATION (City, town, or county) (State) Bethel, N. C. | | | | | | | | | | | | |
| 25A. DATE OF DEATH DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR George H. Kilar | | | | ADDRESS 1348 N. Calhoun St | | | | | | | | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

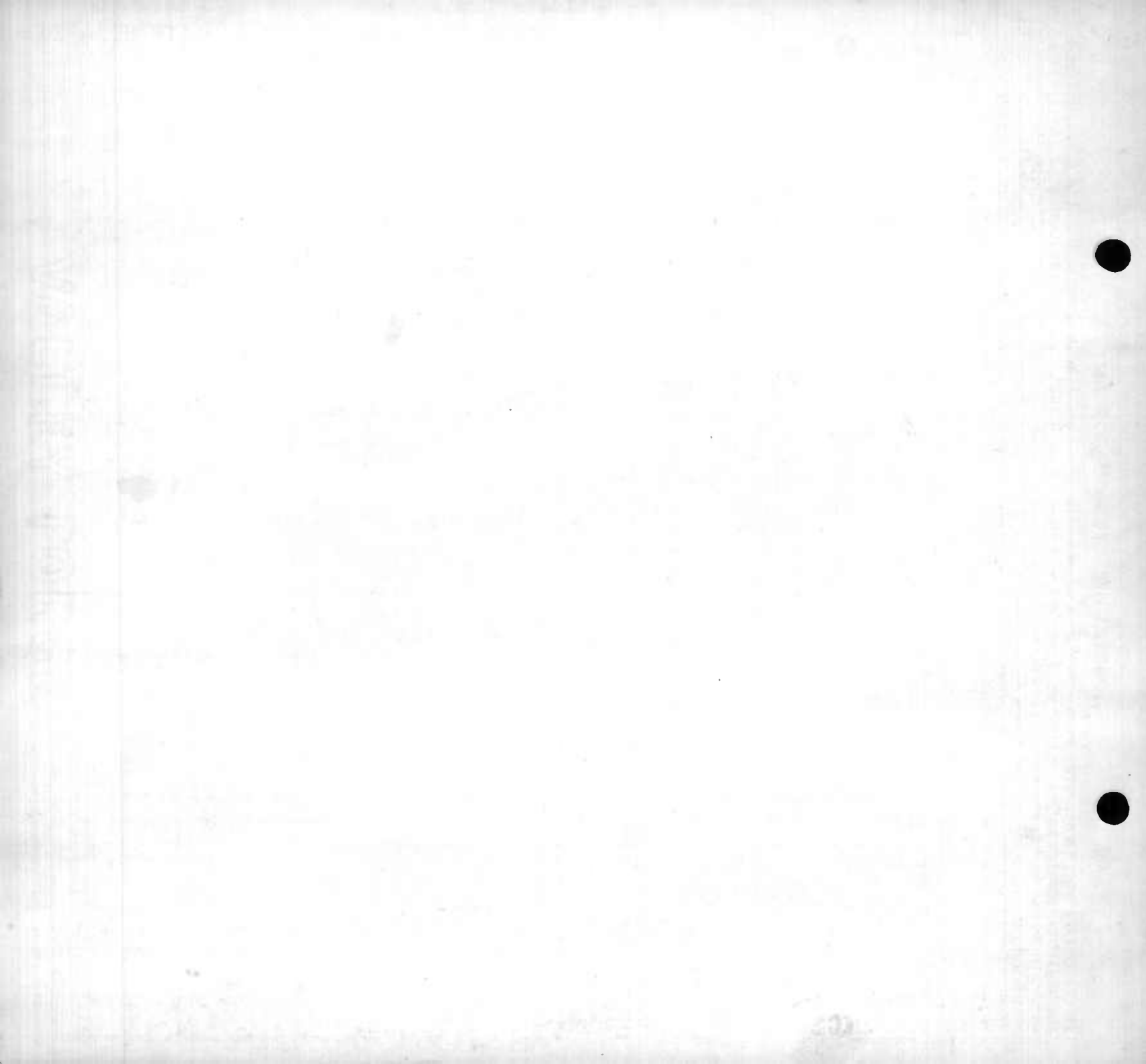
| BIRTH NO. 65 13375 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13375 | |
|--|------------------|--|--|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Lucas Small</i> | | | | 2. DATE AND HOUR OF DEATH <i>December 27, 1965 - 9:00 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>UNIVERSITY HOSPITAL</i> | | | | A. STATE <i>MARYLAND</i> B. COUNTY <i>MD</i> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>1058 Argyle Ave., Apt. 8E</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>C</i> | 7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)) | | 8. DATE OF BIRTH <i>1-26-1903</i> | 9. AGE (In years last birthday) <i>62</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Florida</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | | 16. SOCIAL SECURITY NO. <i>103-58-4983</i> | | 17. INFORMANT ADDRESS <i>Ruth Small 1058 Argyle Ave</i> | |
| 18. 330 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH <i>Subarachnoid Hemorrhage</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>7 hours 50 minutes</i> | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.) | | | | (B) DUE TO (C) | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 27</i> 19 <i>65</i> to <i>Dec. 27</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Dec. 27</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Rolando M. Sabunano</i> M.D. | | | | 23B. DATE SIGNED <i>12-27-65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>ROLANDO M. SABUNANO</i> M.D. | | | | 23D. ADDRESS <i>UNIV. Assp. Neurology</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/30/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Feltman</i> | | 25C. FUNERAL DIRECTOR <i>George A. Kline</i> | | ADDRESS <i>1348 N. Calhoun St</i> | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 65 13376

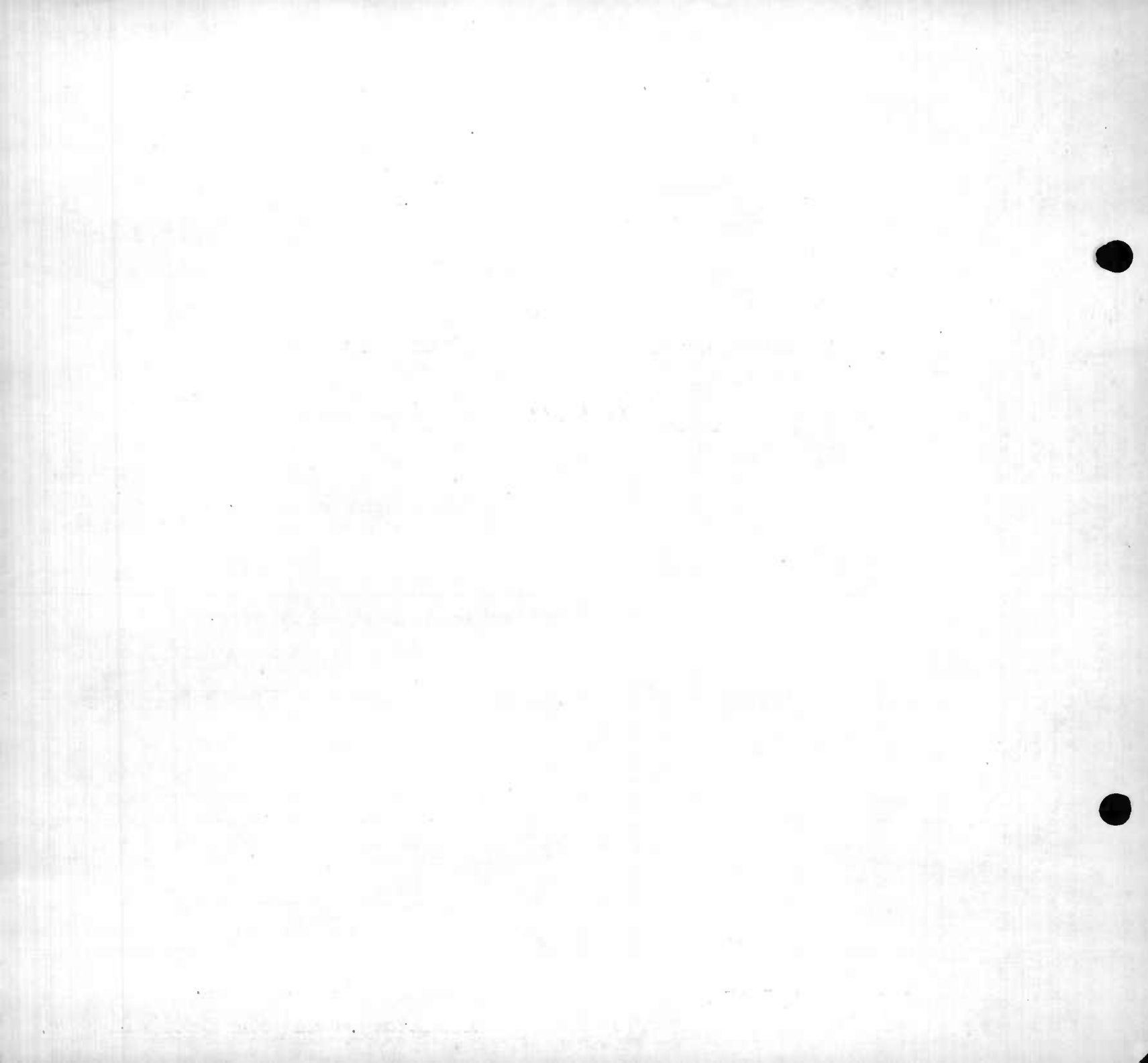
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|--|--|--|--|--|--|
| BIRTH NO. 65 13376 | | CERTIFICATE OF DEATH | | 65 13376 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | Levin Mason | | December 28, 1965 8:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | Maryland | |
| 39 Provident Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| 1514 Division Street | | D. STREET ADDRESS (If rural, give location) | | 1410 Riggs Avenue | |
| Baltimore, Maryland | | 5. SEX | | 6. RACE | |
| Male | | Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | |
| Married | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | |
| 3-23-94 | | 77 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | | | Worcester Co. Va | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| | | John Mason | | Mattie Cannon | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | 216-10-5928 | | Homer Mason (wife) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | ADDRESS | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 1410 Riggs Ave | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Arterio sclerotic disease of heart | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 12/23/65 | | extension of ureter | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/26/65 to 12/28/65 | | that (I) (we) lost saw the deceased alive on 12/28/65 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | M.D. | | | |
| MOONDAY | | Provident Hosp Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/27/65 | | Arbutus M. Park | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE | | | |
| Baltimore | | Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 30 1965 | | Robert E. Stokely | | Z. Brooke Ringgold | |
| ADDRESS | | | | 1463 N. Carey St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

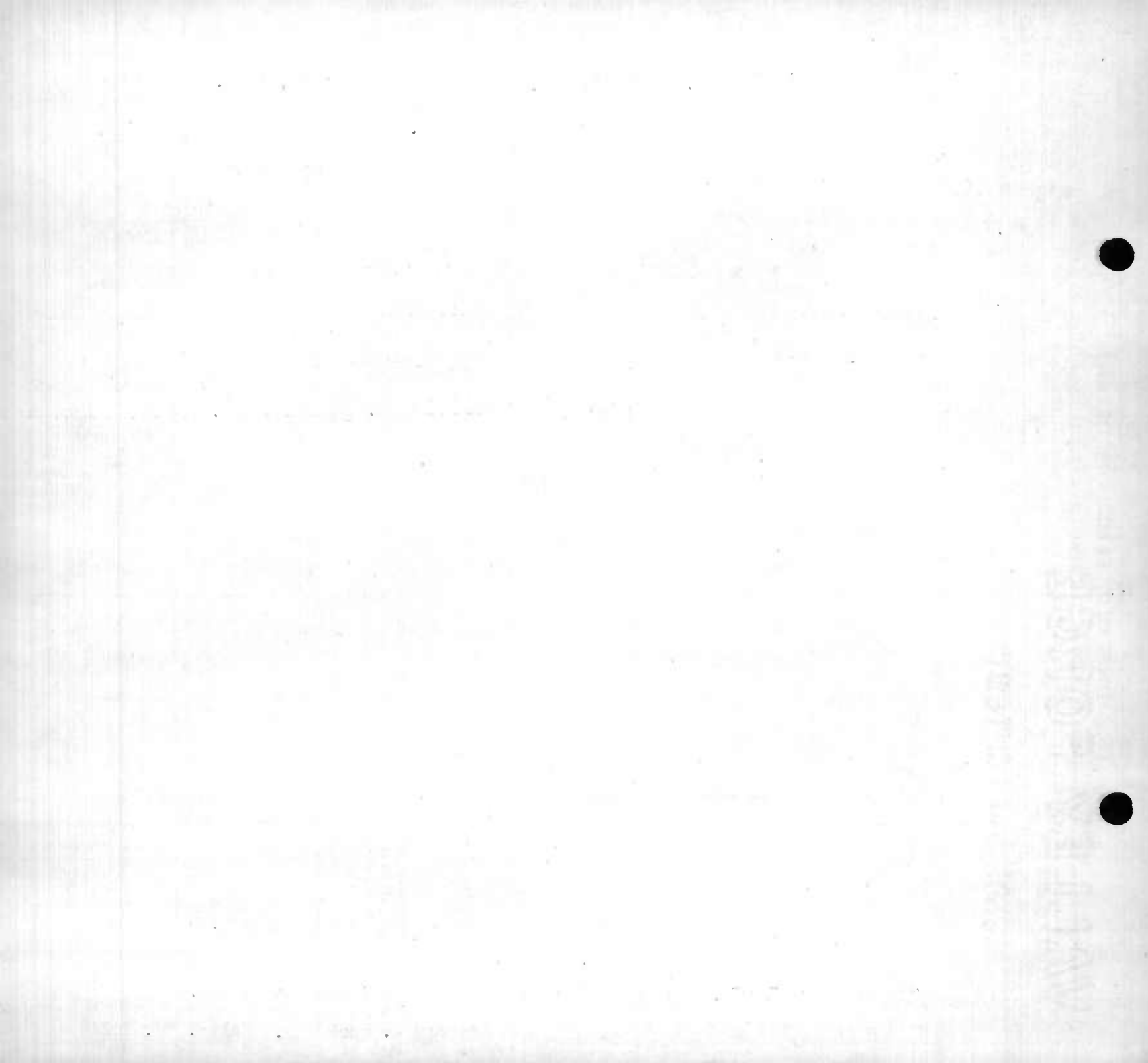
| BIRTH NO. 65 13377 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13377 | |
|---|------------------------------|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) BATZER, JOSEPH P. | | | | 2. DATE AND HOUR OF DEATH December 28, 1965 5:50 a. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, Baltimore B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6201 Malora Road. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 4/22/20/11/04 | 9. AGE (In years lost birthday) 61 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery worker | | 10B. KIND OF BUSINESS OR INDUSTRY Brewery | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME XXXXXXXXXX Joseph Batzer | | | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXX Nan Wilson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214019311 | | 17. INFORMANT Chart, patient's son-in-law. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 053.4 & 008.1 X (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Aspiration of vomitus Shock Gastrointestinal bleeding Sepsis 3 days | | | | INTERVAL BETWEEN ONSET AND DEATH 1 minute 8 hours unknown, but less than 2 days | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Old tuberculosis, hypopituitarism, CNS syphilis | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-24 1965 to December 28 1965 , that (I) (we) last saw the deceased alive on December 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Edgar W. Hull | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) Edgar W. Hull | | | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | 24B. DATE 12-31-65 | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert S. Felt | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

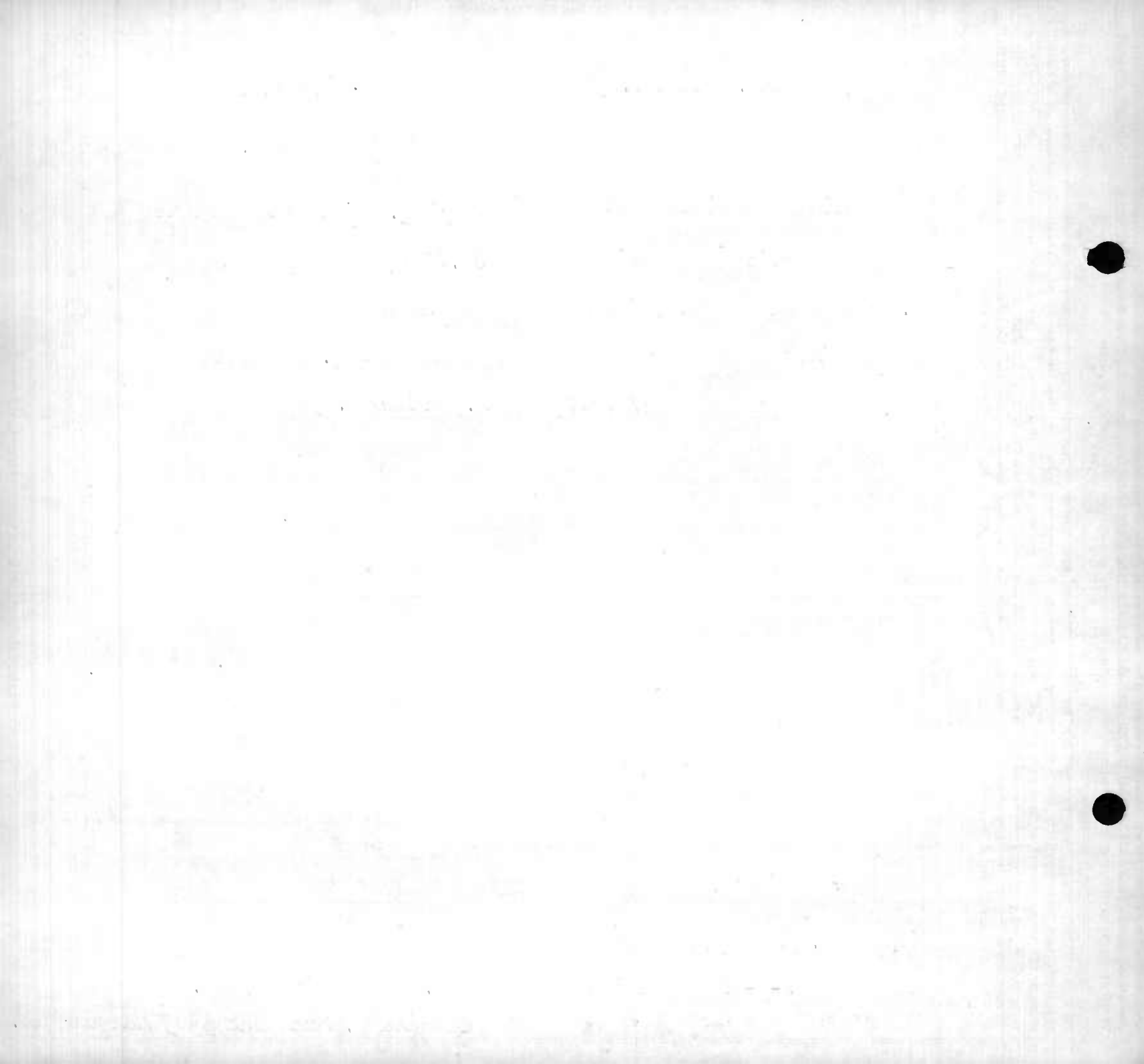
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13378 | |
|---|------------------------------|--|---|--|---|
| BIRTH NO. 65 13378 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>William A. Geckle, Sr.</u> | | 2. DATE AND HOUR OF DEATH <u>December 28, 1965. 1 3:30 P. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>9-04</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1123 Fillmore Street</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1123 Fillmore Street</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u> | 8. DATE OF BIRTH <u>May 13, 1908</u> | 9. AGE (In years last birthday) <u>57</u> | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>August Geckle</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Eberle</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>214017403</u> | | 17. INFORMANT <u>421 Sudbury Road</u> <u>William A. Geckle, Jr. Linthicum Hgts</u> | |
| 18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>Chronic congestive heart failure</u> <u>Arteriosclerotic heart disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>years</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pulmonary emphysema</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/12/55</u> 19 to <u>12/28/65</u> 19, that (I) (we) last saw the deceased alive on <u>12/26/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <u>12/28/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MARION FRIEDMAN</u> | | 23D. ADDRESS <u>5211 Hartford Rd</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | 24B. DATE <u>12-31-65</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1965</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> | |
| | | | | ADDRESS <u>Balto. Md. 21214</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13379 | |
|---|----------------------------|--|--|---|---|
| BIRTH NO. 65 13379 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Nellie Gay Mrs. Ellen T. Gay | | 2. DATE AND HOUR OF DEATH Dec. 28 1965 ³⁰ 10 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | A. STATE Maryland B. COUNTY 21-38 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) 2072 E. Belvedere Avenue | | | |
| 5. SEX Female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH Nov. 13, 1900 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Dietician | | 10B. KIND OF BUSINESS OR INDUSTRY Hospital | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Joseph Airey | | | 14. MOTHER'S MAIDEN NAME Margaret E. Kelleher | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212121196 | 17. INFORMANT Mr. Andrew W. Gay | | ADDRESS same |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | (A) DUE TO Coronary Thrombosis | | (B) DUE TO Cardiac Vascular Renal disease | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO Cardiac Asthma | | (B) DUE TO Syn. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 10, 1961 19 to Dec 8 19 65 , that (I) (we) last saw the deceased alive on 12-26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael J. Grossfeld | | | | 23B. DATE SIGNED 12-29-65 | |
| 23C. PHYSICIAN'S NAME (Type) Michael J. Grossfeld | | 23D. ADDRESS 5404 Belvoir Rd. Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | 24B. DATE 1-3-66 | 24C. NAME of CEMETERY or CREMATORY Baltimore Nat'l Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Fadyema | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc | |
| | | | | ADDRESS 5305 Harford Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13380 | | REGISTERED NO. 65 13380 | |
|--|---------------------|---|--------------------------------------|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>WILLIAM J. JOSITIS (Josaitis)</i> | | | | 2. DATE AND HOUR OF DEATH <i>DEC. 28, 1965</i> <i>11¹⁰ A.</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 MERCY HOSPITAL</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>27-34</i> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>3721 FRANKFORD AVE.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>7-19-1898</i> | 9. AGE (In years last birthday) <i>67</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Tailor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>clothing</i> | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>GEORGE JOSITIS</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Anna (Last name not known)</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> | | 16. SOCIAL SECURITY NO. <i>216050299</i> | | 17. INFORMANT <i>Margaret E. Jositis</i> | | ADDRESS <i>same</i> | |
| 18. <i>451 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) CAUSE OF DEATH <i>RUPTURE OF DISSECTING AORTIC ANEURYSM</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>ACUTE</i> | |
| | | | | (B) <i>GENERALIZED ARTERIOSCLEROSIS</i> | | <i>CHRONIC</i> | |
| | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CORONARY ARTERY DISEASE</i> | | | | | | <i>CHRONIC</i> | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>DEC 19 1965</i> to <i>DEC 28 1965</i> , that (I) (we) last saw the deceased alive on <i>DEC 28 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>David Nagel</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>Dec 28, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>J. DAVID NAGEL</i> | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>12-31-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talbot</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13381 | | CERTIFICATE OF DEATH | | Registered No. 65 13381 | |
|--|--|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>John George Warns</i> | | | | 2. DATE AND HOUR OF DEATH <i>Dec. 28, 1965</i> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Gould Convalescent Home</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2602</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>4304 Southern Avenue</i> | | | | 5. SEX <i>male</i> | | 6. RACE <i>white</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i> | |
| 8. DATE OF BIRTH <i>Aug. 15, 1904</i> | | 9. AGE (In years last birthday) <i>61</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caretaker, Holy Redeemer cemetery</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Francis Warns</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Catherine Klein</i> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | |
| 16. SOCIAL SECURITY NO. <i>216037198</i> | | 17. INFORMANT <i>Mrs. Margaret M. Warns</i> | | | | ADDRESS <i>same</i> | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Cerebral Hemorrhage</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i> | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Acute Myocardial Infarction</i> <i>Hypertensive Cardiovascular Disease</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cirrhosis, Got, Chr. Nephritis & Uremia</i> | | | | 20. DATE OF OPERATION <i>0</i> | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>no</i> | | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i> | |
| 23A. SIGNATURE <i>Albert D Bradley</i> | | 23B. DATE SIGNED <i>12/29/65</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Albert Bradley</i> | | 23D. ADDRESS <i>4900 Belair Road</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/31/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1965</i> | | 25B. NAME OF REGISTRAR <i>Albert E. Farnham</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | | ADDRESS <i>5305 Harford Rd.</i> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|--|--|--|--|--|--|
| 5-512 | | 65 13382 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13382 | |
| BIRTH NO. | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>SIMPSON, MARGARET</u> | | | | 2. DATE AND HOUR OF DEATH <u>12/28/65</u> <u>12 05</u> P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSP</u> | | (If not in hospital or institution, give street address or location) | | A. STATE <u>MD</u> | | B. COUNTY <u>BALTO</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u> | | D. STREET ADDRESS (If rural, give location) <u>9616 MASON AVE</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u> | | 8. DATE OF BIRTH <u>1/1/97</u> | 9. AGE (In years last birthday) <u>68</u> | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARY Land</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George M. Lhs</u> | | | | 14. MOTHER'S/MAIDEN NAME <u>UNKNOWN</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>RICHARD (SON) WOODROW</u> | | ADDRESS <u>2313 WALKER AVE BALTO MD</u> | |
| 18. <u>433.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>pulmonary edema</u> | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>atrial fibrillation</u> | | | | (B) DUE TO | | <u>1 yr</u> | |
| | | | | (C) <u>ASCVD</u> | | <u>9 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> <u>1965</u> to <u>12/28</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Charles S. Brown</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/28/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>CHARLES S. BROWN</u> | | | | 23D. ADDRESS M.D. <u>UNION MEMORIAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12/30/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>PARKWOOD</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Chas E. Taylor</u> | | ADDRESS <u>8802 HARTFORD RD</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

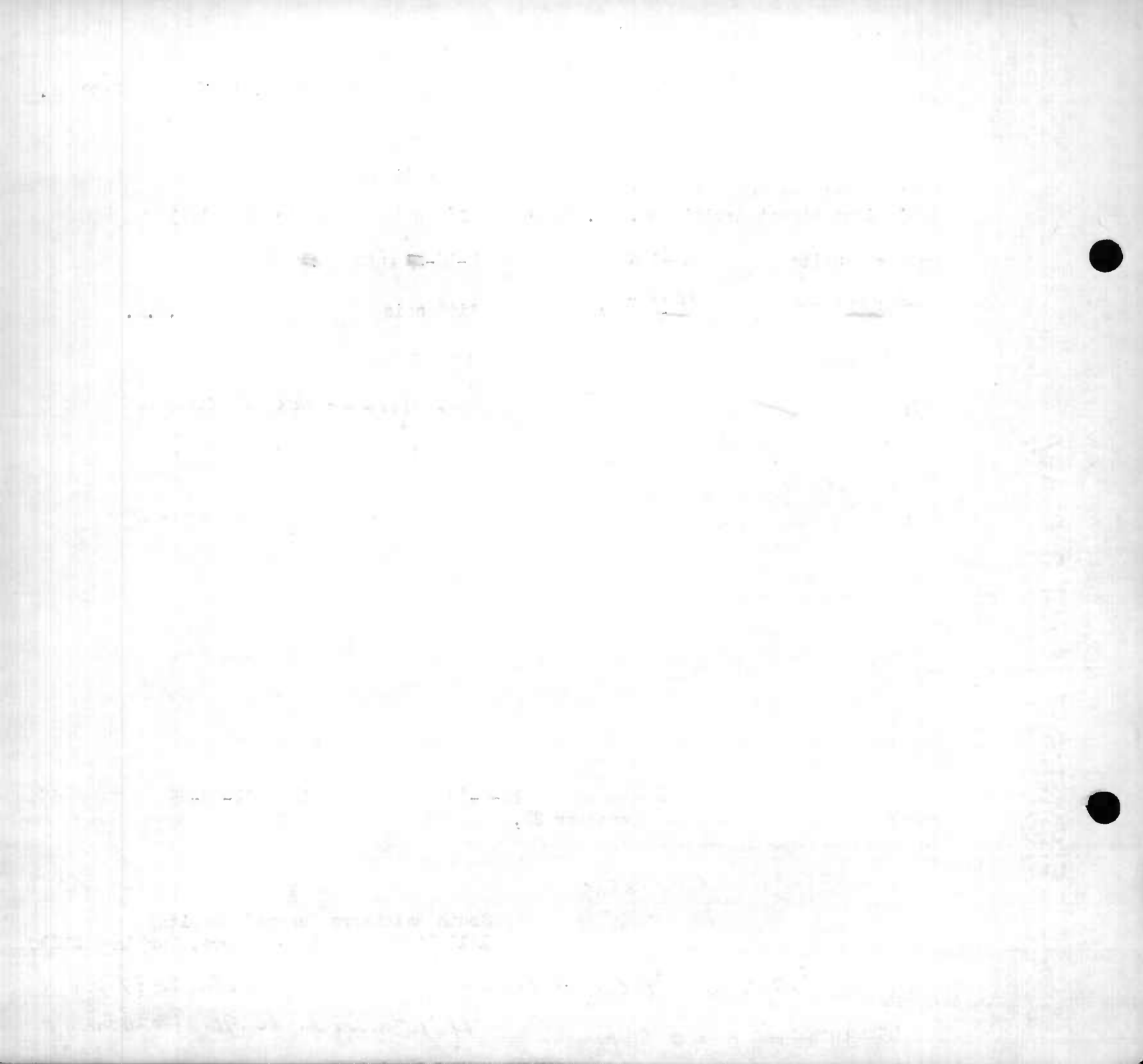
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 13383 | |
|---|-------------------------|---|--------------------------------------|--|---|--|--|
| BIRTH NO. 65 13383 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Julia Urban [MUZAIKA, RISZKO] | | 2. DATE AND HOUR OF DEATH December 28, 1965 11:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital 1213 Light Street Baltimore, Md. 21230 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 906 South Garry Street 21223 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-16-1885 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY Tackling Co. | | 11. BIRTHPLACE (State or foreign country) Lithuania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Mat Urban - 906 S. Garry St - (23) | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 434.1 I | | CAUSE OF DEATH (A) DUE TO Pulmonary embolization (B) DUE TO Chronic Congestive Heart Failure (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-1-65 19 65 to 12-28-65 19 65 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 28, 1965 and that in XXX (our) opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> (he) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald C. Roane M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) Donald C. Roane M.D. | | | | 23D. ADDRESS South Baltimore General Hospital 1213 Light Street Baltimore, Maryland 21230 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY Not Christ Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. J... | | 25C. FUNERAL DIRECTOR John P. ... | | ADDRESS 901 Hallway St | |

DEC 30 1965

Robert E. J...

John P. ...

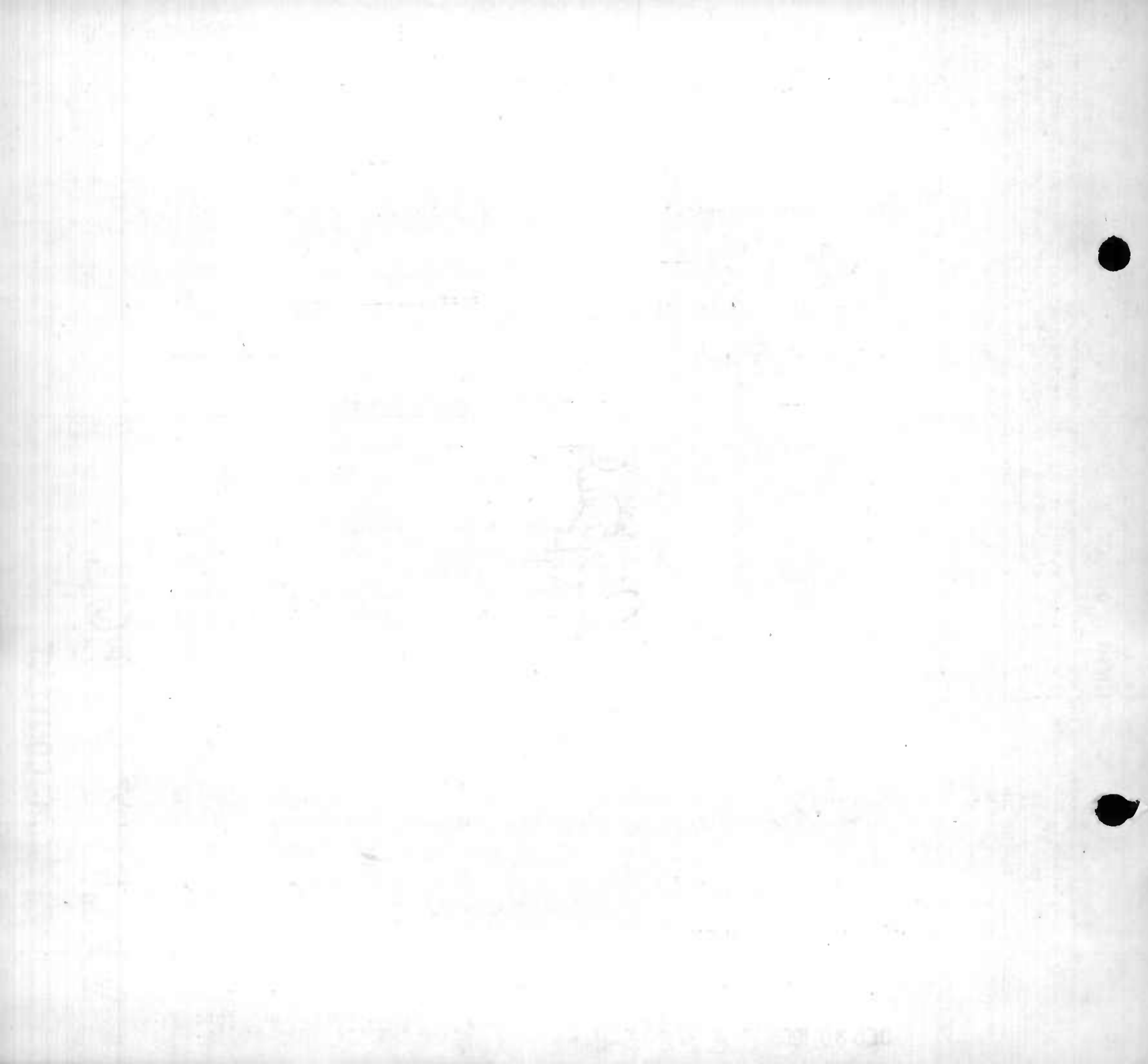
901 Hallway St



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 13384 | |
|---|-------------------------|---|------------------------------------|--|-----------------------------|--|------------------------------|
| BIRTH NO. 65 13384 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GEORGE B. ROBERTS, Sr. | | 2. DATE AND HOUR OF DEATH 12/26/65 7:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 4 UNION M. Hospital Union Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2708 CHESLEY AVE | | | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/25/89 | 9. AGE (In years last birthday) 76 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME GEORGE ROBERTS | | | | 14. MOTHER'S MAIDEN NAME Bartlett FLORENCE BARTLETT (D) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-01-4749 | | 17. INFORMANT Rose M. Roberts (Wife) | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH FX @ Hip. HEART FAILURE | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 12/22/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FX @ Hip | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2708 Chesley Ave 27-07 | | 21F. HOW DID INJURY OCCUR? Fell in living room | |
| 21D. TIME OF INJURY (APPROX.) 12 20 65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/21 19 65 to 12/26 19 65 , that (I) (we) last saw the deceased alive on 12/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE VICTOR M. RODRIGUEZ | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) VICTOR M. RODRIGUEZ | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/29/65 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Eugenia K. Seitz | | 25C. FUNERAL DIRECTOR Seitz Funeral Home | | ADDRESS 5209 York Rd. Balto. Md. 2 1212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13385 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13385 | |
|---|--|---|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Abraham Russell | | | | 2. DATE AND HOUR OF DEATH December 25, 1965 1 12 noon | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3702 Yosemite Avenue Baltimore, Maryland 21215 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3702 Yosemite Avenue | | | | | |
| 5. SEX Male | | 6. RACE Colored | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH Feb. 27, 1915 | | 9. AGE (In years lost birthday) 50 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheerman | | | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Yes Abraham Russell | | | | 14. MOTHER'S MAIDEN NAME Cornelia Pride | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII | | | | 16. SOCIAL SECURITY NO. 224-10-3640 | | 17. INFORMANT Edna Russell 3702 Yosemite Avenue | | | |
| 18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RENAL + TERMINAL HEART FAILURE | | | | CAUSE OF DEATH (A) DUE TO GENERALIZED CARCINOMA | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO MATOSIS | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/27 19 65 to 12/25 19 65 , that (I) (we) last saw the deceased alive on 12/25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE G. L. BANFIELD | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/27/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) G. L. BANFIELD | | | | 23D. ADDRESS 722 N. Fulton Ave | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-30-65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 Monroe St. | | | |

65 13386

BALTIMORE CITY HEALTH DEPARTMENT

65 13386

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VERNON McMICKLE

Vernell

2. DATE AND HOUR PRONOUNCED DEAD

December 26, 1965

11:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

611 N. Carrollton Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/4/1937

9. AGE (In years
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Bubber McMickle

14. MOTHER'S MAIDEN NAME

Nattie Bradley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Leroy Andrews 1214 W. Lexington St.

18. 3333

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries sustained
during epileptiform convulsive seizure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (a.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Unknown

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Unknown

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-27-65

23A. BURIAL CREMATION,
REMOVED (Specify)

Removal

23B. DATE

12/29/65

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Lynchburg

S.C.

24A. DATE REC'D BY HEALTH DEPT.

DEC 30 1965

24B. NAME OF REGISTRAR

R. E. Fisher

24C. FUNERAL DIRECTOR

Arlington Phillips 1727 N. Monroe St.

ADDRESS

11/19/31
M. J. Smith
R. J. Smith
R. J. Smith
R. J. Smith

R. J. Smith
R. J. Smith
R. J. Smith
R. J. Smith

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 65 13387 | | Baltimore City Health Department | | Registered No. 65 13387 | |
|--|-------------------------|--|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mattie Knight</i> | | | | 2. DATE AND HOUR OF DEATH <i>12-24-65</i> <i>7:30</i> P. M. | | | |
| 3. PLACE OF DEATH (In Baltimore, Maryland) CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1/7/66</i> BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY <i>16-07</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1505 N. HILTON ST. #21216 | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH <i>1/10/03</i> | 9. AGE (In years lost birthday) <i>62</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maid</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME <i>Anthony Mc Quay</i> | | | | |
| 14. MOTHER'S MAIDEN NAME <i>Mary Scott</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>212-12-9316</i> | | | | |
| 16. SOCIAL SECURITY NO. <i>212-12-9316</i> | | | 17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE #21224 | | | | |
| 18. <i>600.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Uremia and Anemia</i> DUE TO (B) <i>Chronic pyelonephritis</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks +</i> <i>4 weeks plus</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diffuse Arteriosclerosis</i> | | | | <i>ind + units</i> | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/20</i> 19 <i>65</i> to <i>12/24</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>11/24</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Robert R. Kent</i> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> <i>Inten</i> | | 23B. DATE SIGNED <i>12-24-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert R. Kent</i> M.D. | | | | 23D. ADDRESS <i>Baltimore City Hospitals</i> 4940 EASTERN AVENUE #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/29/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Calhoun Mem. Pl.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Arlington Phillips</i> ADDRESS <i>1727 N. Mount St.</i> | | | |

letter from hosp. to add father's and mother's name. C. B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---|--|--|
| BIRTH NO. 65 13388 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13388 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Susie Lemon P. | | | 2. DATE AND HOUR OF DEATH December 29, 1965 4:45 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased resided, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | | A. STATE Maryland B. COUNTY Baltimore | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2327 W. Lanvale Street | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | B. DATE OF BIRTH 12-25-1893 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Frank Page | | 14. MOTHER'S MAIDEN NAME Martha Carter | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edith Faulkner | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X | | CAUSE OF DEATH (A) C.V.A. DUE TO (B) Arteriosclerotic and hypertensive DUE TO (C) cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 28, 1965 to December 29, 1965 , that (I) (we) last saw the deceased alive on December 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED December 29, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) A. Rigaud | | 23D. ADDRESS 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/2/66 | | 24C. NAME OF CEMETERY or CREMATORY Shepherdville | |
| 24D. LOCATION (City, town, or county) Gloucester | | 24E. LOCATION (State) Virginia | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. F... | | 25C. FUNERAL DIRECTOR William J. Phillips | |
| | | | | ADDRESS 1727 N. Monroe | |

James M. Smith
2nd Regt. Infy

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March 27
2nd Regt. Infy

March 11th 1862

James M. Smith
2nd Regt. Infy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13389 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13389 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mr Charles Luther Phillips | | | | 2. DATE AND HOUR OF DEATH 12/29/65 8:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 224 Northway | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5/18/89 | 9. AGE (In years lost birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive | | 10B. KIND OF BUSINESS OR INDUSTRY U.S.F+G | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Phillips | | | 14. MOTHER'S MAIDEN NAME Jessie O Dell | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-07-8491 | | 17. INFORMANT Gladys L. Phillips | | ADDRESS Above | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH 1 day ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3 days II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (A) Myocardial Infarct DUE TO (B) Pneumonia DUE TO (C) Hypertensive arteriosclerosis 10 yrs. Heart Disease | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Dec 28 1965 to Dec 29 1965, that (1) (we) lost saw the deceased alive on Dec 29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Alan Bernard Cohen | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) Alan Bernard Cohen | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-31-65 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge | | 24D. LOCATION (City, town, or county) (State) Pikesville Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Feltz | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. | | | |

ALAN TERRY A. CLEGG

ALAN TERRY A. CLEGG

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| 65 13390 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13390 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 91 Monte Carlo Hospital | | Maryland | | 1100 | |
| 176/66 | | D. STREET ADDRESS (If rural, give location) | | 14 W. Real St. | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| Female | | White | | WIDOWED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH (last birthday) | |
| Social Worker | | | | 4/6/1874 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| William F. Knox | | Sally Ann Mudge | | 91 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | 217-22-1933 | | Hospital Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Hyperkalemia and arteriosclerosis some years. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Heart Disease | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| MEDICAL CERTIFICATION | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/2/65 to 12/29/65, that (I) (we) last saw the deceased alive on 12/29/65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| Daniel G. Lai | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 12/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR | |
| Daniel G. Lai | | M.D. 2201 Argonne Drive, Baltimore 18, Md. | | H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Cremation | | 12/30/1965 | | Greenmount | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE | | 24F. DATE REC'D BY HEALTH DEPT. | |
| Baltimore, Maryland | | 24G. NAME OF REGISTRAR | | 24H. DATE REC'D BY HEALTH DEPT. | |
| 24I. NAME OF REGISTRAR | | 24J. DATE REC'D BY HEALTH DEPT. | | 24K. DATE REC'D BY HEALTH DEPT. | |
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letter from hosp. C.B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 13391</u> | |
|---|-------------------------|---|---|---|---|
| BIRTH NO. <u>65 13391</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>William M. Heaphy</u> | | | 2. DATE AND HOUR OF DEATH <u>December 28, 1965</u> <u>9:40 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u> <u>1213 Light Street Baltimore, Md. 21230</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>6102 Fairdel Avenue 21206</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>8-26-06</u> | 9. AGE (In years lost birthday) <u>69</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Weigher)</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>American Smelting Co</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>William</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Randall</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u> | | |
| 16. SOCIAL SECURITY NO. <u>212-10-1581</u> | | | 17. INFORMANT <u>Minnie Heaphy - 6102 Fairdel Avenue</u> | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11-9-65</u> <u>1965</u> to <u>12-28-65</u> <u>1965</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>December 28, 1965</u> <u>19 65</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Kermit P. Bonovich</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>12-28-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Kermit P. Bonovich</u> | | | | 23D. ADDRESS <u>South Baltimore General Hospital</u> <u>1213 Light Street Balto., Md. 21230</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12-31-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | |
| 24D. LOCATION <u>Baltimore Maryland</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1965</u> | | | |
| 24F. NAME OF REGISTRAR <u>Robert E. Sullivan</u> | | 24G. FUNERAL DIRECTOR <u>John C. Miller Inc-6415 Belair Rd.-21206</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13392 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13392 | |
|--|---------------------|---|--|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) MARTHA A. WADE | | | | 2. DATE AND HOUR OF DEATH 12.25.65 7:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 18-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Srs of the Poor 1200 Valley St. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1200 Valley St | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 11.25.1973 | 9. AGE (In years last birthday) 92 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balt. MD | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Michael Wade | | | |
| 14. MOTHER'S MAIDEN NAME Ellen Norton | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. None | | | | 17. INFORMANT ADDRESS Little Srs. of the Poor | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I Pulmonary edema | | | | CAUSE OF DEATH A.S.C.V.D. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to Dec 25 19 65 , that (I) (we) last saw the deceased alive on Dec 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Stanley Ankudars M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12.27.65 | |
| 23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDARS M.D. | | | | 23D. ADDRESS 1802 W. 3rd St. Balt. MD 21223 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/29/65 | | 24C. NAME of CEMETERY or CREMATORY Cathedral | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Felt | | 25C. FUNERAL DIRECTOR Philip Herurg Sons | | ADDRESS 2024 Orleans St | |

BIRTH NO. 65 13393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 13393

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD Muller WENCK Sr.

2. DATE AND HOUR PRONOUNCED DEAD

December 28, 1965 2:30P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2244 Sidney Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

Jan. 13, 1918

9. AGE (In years
last birthday)

47

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Janitor

10B. KIND OF BUSINESS OR INDUSTRY

City of Baltimore

11. BIRTHPLACE (State or foreign country)

Brunswick, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Millard F. Wenck Jr.

14. MOTHER'S MAIDEN NAME

Josephine (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

212-07-2654

17. INFORMANT

Mrs. Edna A. Wenck

ADDRESS

2244 Sidney Avenue (30)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Cor pulmonale
DUE TO chronic pulmonary emphysema

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg.,
etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan. 3, 1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

Baltimore

(City, town, or county)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 30 1965

Wm. Cook-Brooks, Inc.

1217 St. Paul St.

MAILING POLICE

U.S. DEPT. OF JUSTICE

RECEIVED

NOV 10 1964

U.S. DEPT. OF JUSTICE

7-7

[Handwritten signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

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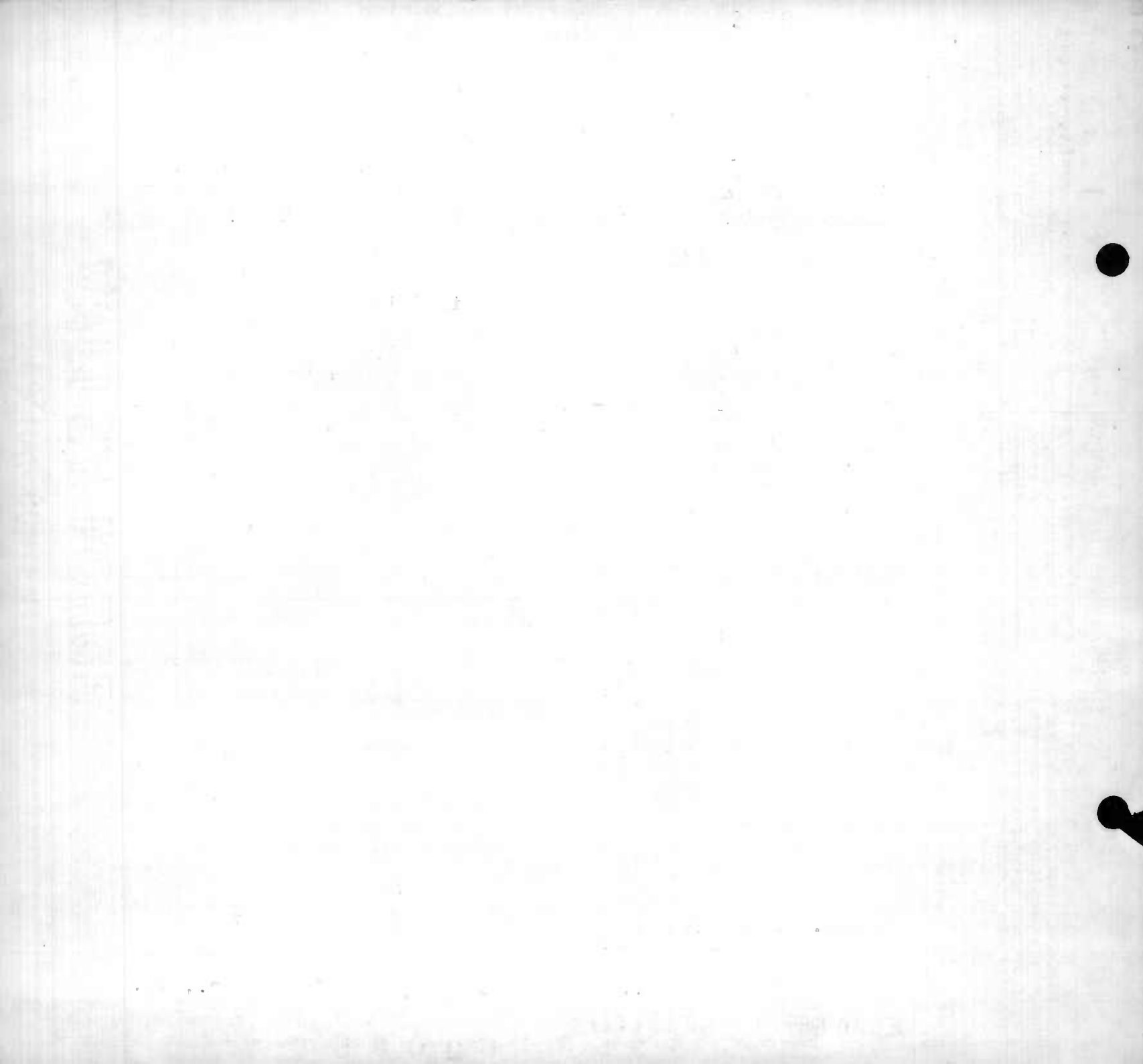
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1894-1895

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13395 | |
|--|-------------------------|--|---|---|--|
| BIRTH NO. 65 13395 | | CERTIFICATE OF DEATH | | | |
| M.F. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>William Jones</i> | | 2. DATE AND HOUR OF DEATH <i>12/23/45 7:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>601 N BROADWAY 21205 The Johns Hopkins Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> B. COUNTY <i>704</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>933 McDonough Street</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>*****</i> | 9. AGE (In years last birthday) <i>57</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Juneter</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>*****</i> | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>235-07-0676</i> | | 17. INFORMANT <i>Mary Jackson</i> |
| | | | ADDRESS <i>Brookneal, Va.</i> | | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>cardiovascular Accident</i> <i>Arteriosclerotic Cardiovascular Disease</i> (B) <i>Due to</i> (C) <i>Due to</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>21 days</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/22</i> 19 <i>45</i> to <i>12/23</i> 19 <i>45</i> , that (I) (we) last saw the deceased alive on <i>12/22</i> 19 <i>45</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>E. Eugene Page</i> | | | | 23B. DATE SIGNED <i>12/23/45</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>E. Eugene Page</i> | | | | 23D. ADDRESS <i>601 N. BROADWAY 21205 Johns Hopkins Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/29/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>St., Joy Bapt Ch Cem.</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Buckingham Co., Va.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fabyant</i> | | 25C. FUNERAL DIRECTOR <i>Blair + Rial Funeral Home</i> | |
| | | | | ADDRESS <i>Va.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13396 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13396 | |
|---|---------------------|--|--------------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CURTIS, ROSIE ETTA Hardy | | | | 2. DATE AND HOUR OF DEATH 12/30/65 10A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL | | | | A. STATE MARYLAND B. COUNTY 4-82 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 770 W. SARATOGA ST. | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9/16/1890 | | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME DANIEL MOORE | | | | 14. MOTHER'S MAIDEN NAME MARY SMITH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Edw. Slaughter 1135 Stockton | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) UREMIA II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Transition of Cell Carcinoma of Bladder | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/30/65 to 12/30/65 , that (I) (we) last saw the deceased alive on 12/30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Andres A. Acosta | | | | 23B. DATE SIGNED 12/30/65 | | 23C. PHYSICIAN'S NAME (Type) Andres A. Acosta | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 1-3-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md | | | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | | | 25C. FUNERAL DIRECTOR Sullivan Funeral Home - N. Arlington | | | |

65 13397

BALTIMORE CITY HEALTH DEPARTMENT

65 13397

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

(Mills-Miller)

2. DATE AND HOUR PRONOUNCED DEAD

1

CATHERINE

QUICKLY

December 30, 1965

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2618 Llewelyn Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

10-18-1927

9. AGE (In years last birthday)

38

If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laundress

10B. KIND OF BUSINESS OR INDUSTRY

Laundry

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James Lee Mills

14. MOTHER'S MAIDEN NAME

Elizabeth Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

William Mills-2554 Robb St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/30/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1-3-66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

Robert E. Feltner

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr. 1735 Harford Ave.

ADDRESS

VALLEY POLICE

AN ORDINANCE

OF THE

CITY OF

VALLEY

AND

THE

BOARD OF

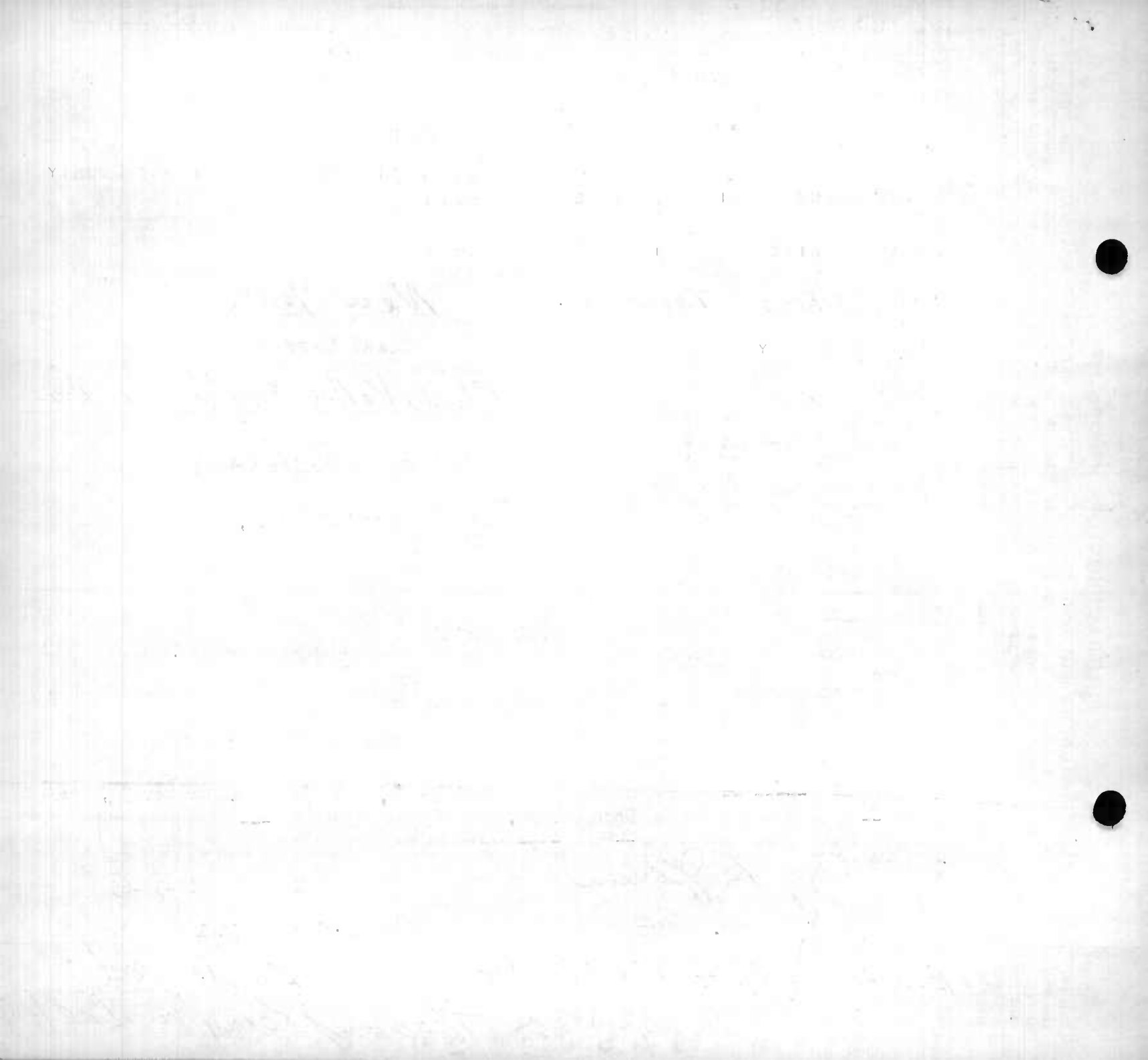
THE

VALLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|----------------------------|--|
| 65 13398 CERTIFICATE OF DEATH | | | | | Registered No. 65 13398 | | | | | |
| BIRTH NO. 65 13398 | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) RUTH KELLER | | | | | 2. DATE AND HOUR OF DEATH 12-30-65 5:00 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | A. STATE MARYLAND B. COUNTY BALTIMORE | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 314 GROVETHORN ROAD | | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | | 8. DATE OF BIRTH 7-6-13 | | 9. AGE (In years lost birthday) 52 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS | | 10B. KIND OF BUSINESS OR INDUSTRY TAILORING | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME GEORGE DORSEY | | | | | 14. MOTHER'S MAIDEN NAME CLARA LAFFLER | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Charles Keller | | | ADDRESS 3114 Kentucky Ave | | |
| 18. 527.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Respiratory and cardiac arrest | | | | | CAUSE OF DEATH (A) DUE TO (B) Diffuse pulmonary infiltrate, ? etiology (C) | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Polymyositis | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 30, 1965 to December 30, 1965 , that (I) (we) last saw the deceased alive on December 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Jay B. Jensen M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 12-30-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Jay B. Jensen M.D. | | | | | 23D. ADDRESS Johns Hopkins Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/3/1966 | | 24C. NAME OF CEMETERY OR CREMATORY Mt Olivewood | | 24D. LOCATION (City, town, or county) (State) Balto md | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | 25C. FUNERAL DIRECTOR Thomas Kenny Jr | | | ADDRESS Balto md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---|--|--|
| BIRTH NO. 65 13399 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13399 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>John Tglehart</i> JOHN W. IGLEHART | | 2. DATE AND HOUR OF DEATH <i>12/28/65</i> 9 a. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Park Hill Nursing Home</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>Howard</i> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Ellicott City</i> <i>6300</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>St. Johns Lane</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>Jan 25, 1898</i> | 9. AGE (In years last birthday) <i>67</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Carpenter Foreman</i> | | 11. BIRTHPLACE (State or foreign country) <i>Henryton, Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Frank Iglehart</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Florence Powers</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. <i>213-01-6929</i> | | 17. INFORMANT ADDRESS <i>Miss Katherine Amoss, Woodbine, Md</i> | | | |
| 18. <i>334X I</i> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Arterio Sclerotic Brain disease</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>sev. months</i> | |
| ANTECEDENT CAUSES | | (B) <i>Jan' Arteriosclerosis</i> | | <i>years</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Aug 17</i> 19 <i>65</i> to <i>Dec 28</i> 19 <i>65</i> , that (I) we lost saw the deceased alive on <i>Dec 27</i> 19 <i>65</i> and that in my <i>my</i> (or) opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Louis V. Blum M.D.</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/28/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Louis V. Blum, M.D.</i> | | 23D. ADDRESS <i>3502 W. Rogers Ave. Balt. 15, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-31-1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. View</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Alpha, Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Faldut</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>F. C. Higginbotham Ellicott City Md</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------|--|--|--|---------------------------------|---|---|----------------------------------|--|
| BIRTH NO. | | 85-13400 | | | | Registered No. 65-13400 | | | |
| M.E. CASE NO. | | 85-13400 | | | | SHENTON | | | |
| 1. NAME OF DECEASED (Type or Print) | | HARRY W. SHENTON | | | | 2. DATE AND HOUR OF DEATH | | 12/30/65 at 12:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | |
| Church Home Hospital | | | | | | Maryland | | Baltimore | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | | | Baltimore | | 3300 | |
| | | | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | | | 7902 Knollwood Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| Male | CCA | married | | April 28, 1895 | 70 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| ATTORNEY | | LAW | | Maryland, Balto. City | | USA | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Frank Shenton | | | | Fannie Taylor | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT: wife | | | ADDRESS | | |
| WW I | | WW I | | 212-14-8897 | | | Dorothy W. Shenton, 7902 Knollwood Rd. Towson | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Cardio arrest | | | | | | | |
| ANTECEDENT CAUSES | | (B) Atherosclerotic heart disease | | | | | | years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Jose A. Mangano | | | | 12-30-65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Jose S. Mangano | | | | Church Home Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 1/1/1966 | | Druid Ridge Cemetery | | Pikesville, Balto. Co., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | | | |
| JAN 3 1966 | | Robert E. Farkley | | Stewart & Mowen Co. 108 W. North Av. City | | | | | |

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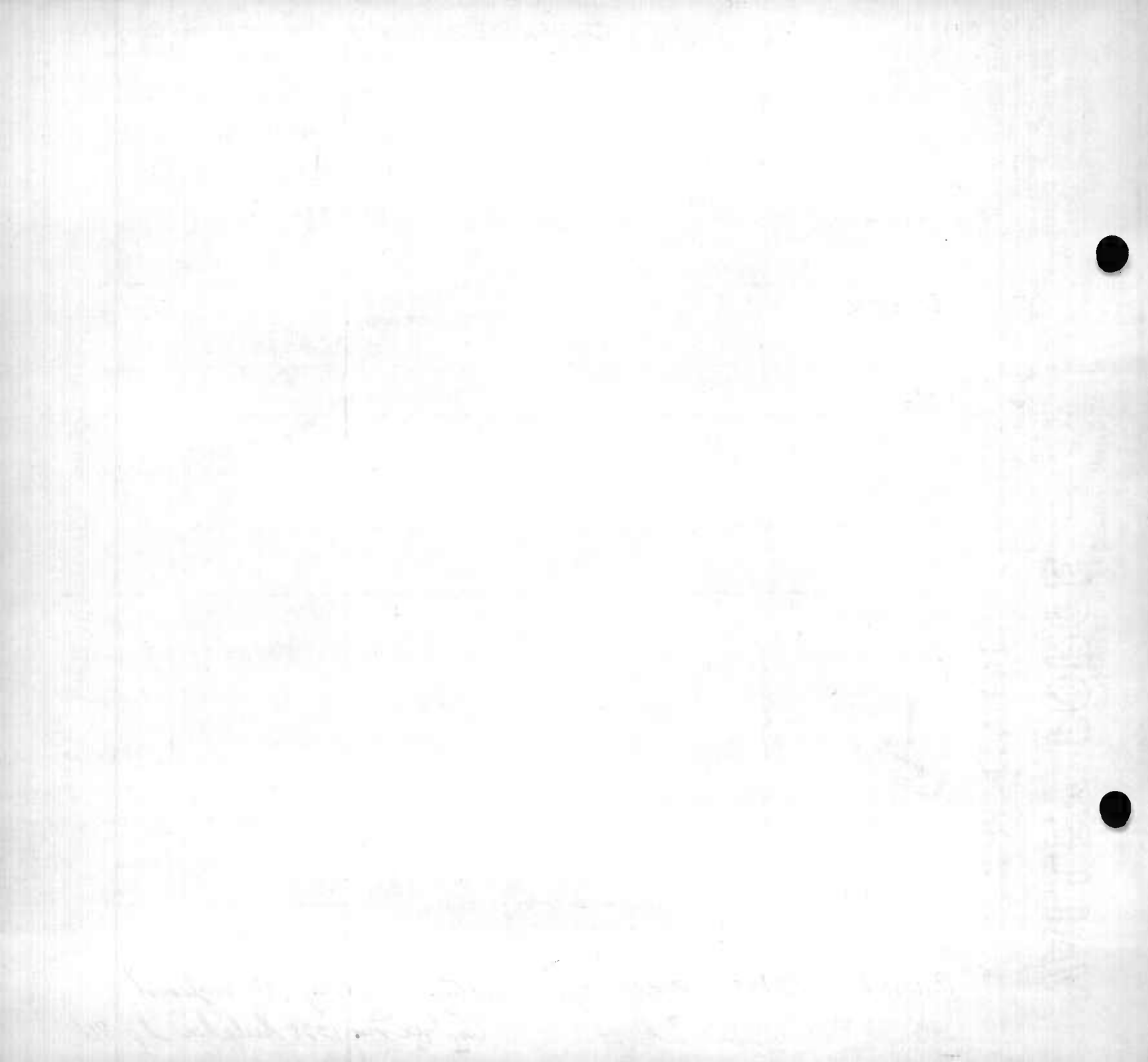
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

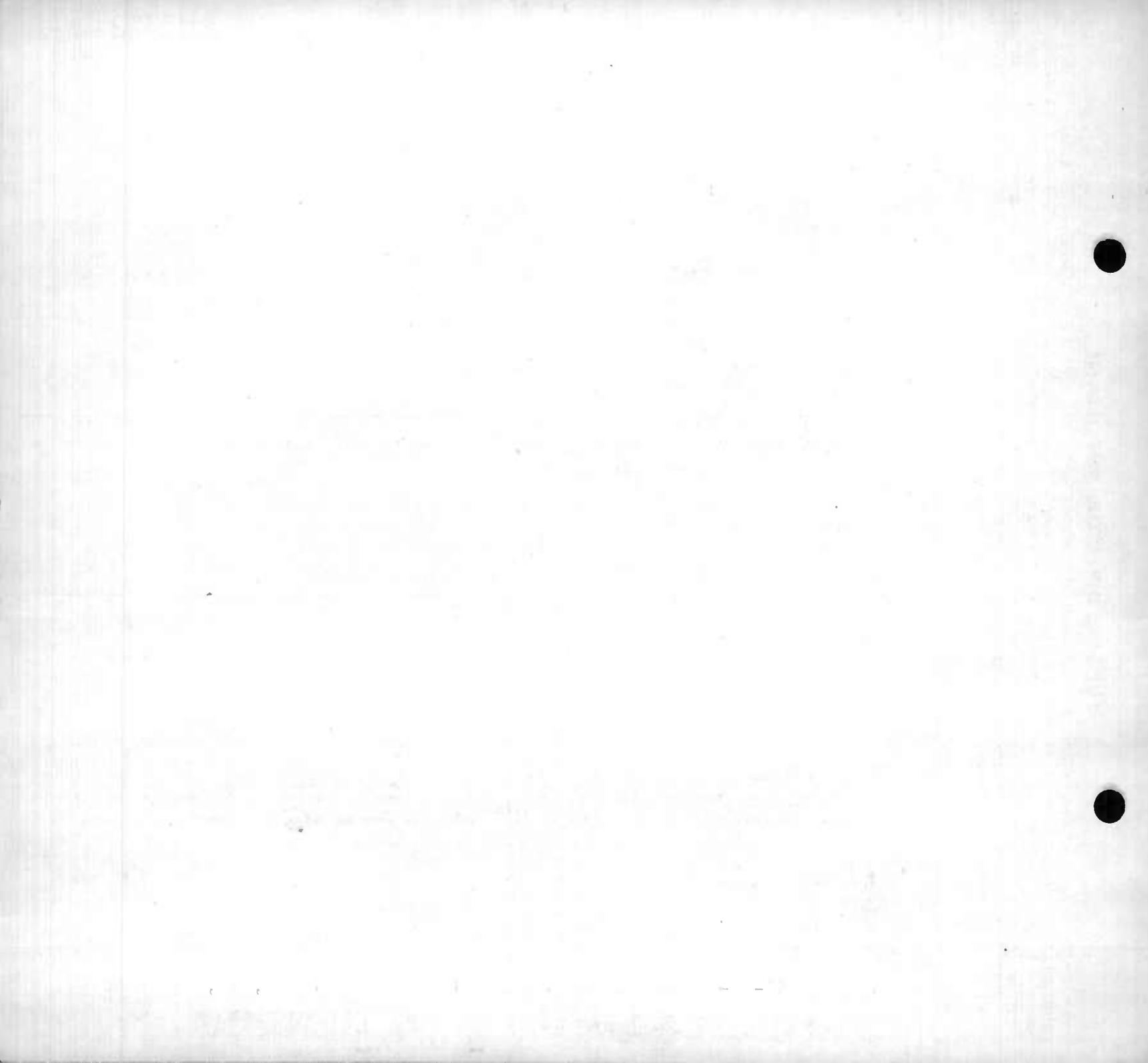
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-----------------------------|--|--|---|---|--|---|-------------------------|--|
| BIRTH NO. 65 13401 | | CERTIFICATE OF DEATH | | | | Registered No. 65 13401 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Helen C. Narer</u> | | | | | 2. DATE AND HOUR OF DEATH <u>12-31-65</u> <u>1</u> <u>9</u> <u>55</u> P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 Maryland General Hospital</u> <u>Baltimore Md</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Linthicum Heights</u> <u>52-00</u> D. STREET ADDRESS (If rural, give location) <u>316 Ardmore Rd</u> | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Caucasian</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>10-9-02</u> | 9. AGE (In years last birthday) <u>63</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retail Store</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | |
| 13. FATHER'S NAME <u>William Knickman</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Stoneseifer</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Pt. on admission</u> | | ADDRESS | | |
| 18. <u>545 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>Peritonitis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Rupture of Gastro colic fistula</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic renal disease</u> | | | | | CAUSE OF DEATH (A) <u>Peritonitis</u> DUE TO (B) <u>Rupture of Gastro colic fistula</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19A. DATE OF OPERATION <u>12-28-65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Closure of perforation</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>12-14</u> 19 <u>65</u> to <u>12-31</u> 19 <u>65</u> , that <u>(1) (we)</u> last saw the deceased alive on <u>12-31</u> 19 <u>65</u> and that in <u>(my) (44)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(1) (we) (did) (44) (not)</u> view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Francis A. Clark Jr</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12-31-65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Francis A. Clark Jr</u> | | | | | 23D. ADDRESS M.D. <u>40 Maryland General Hospital</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/4/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Cemetery</u> | | 24D. LOCATION (City, town, or county) <u>Dorsey, Maryland</u> | | 24E. STATE <u>Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u> | | 25C. FUNERAL DIRECTOR <u>Anthony J. 1328 Sulphur Sp Rd.</u> | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

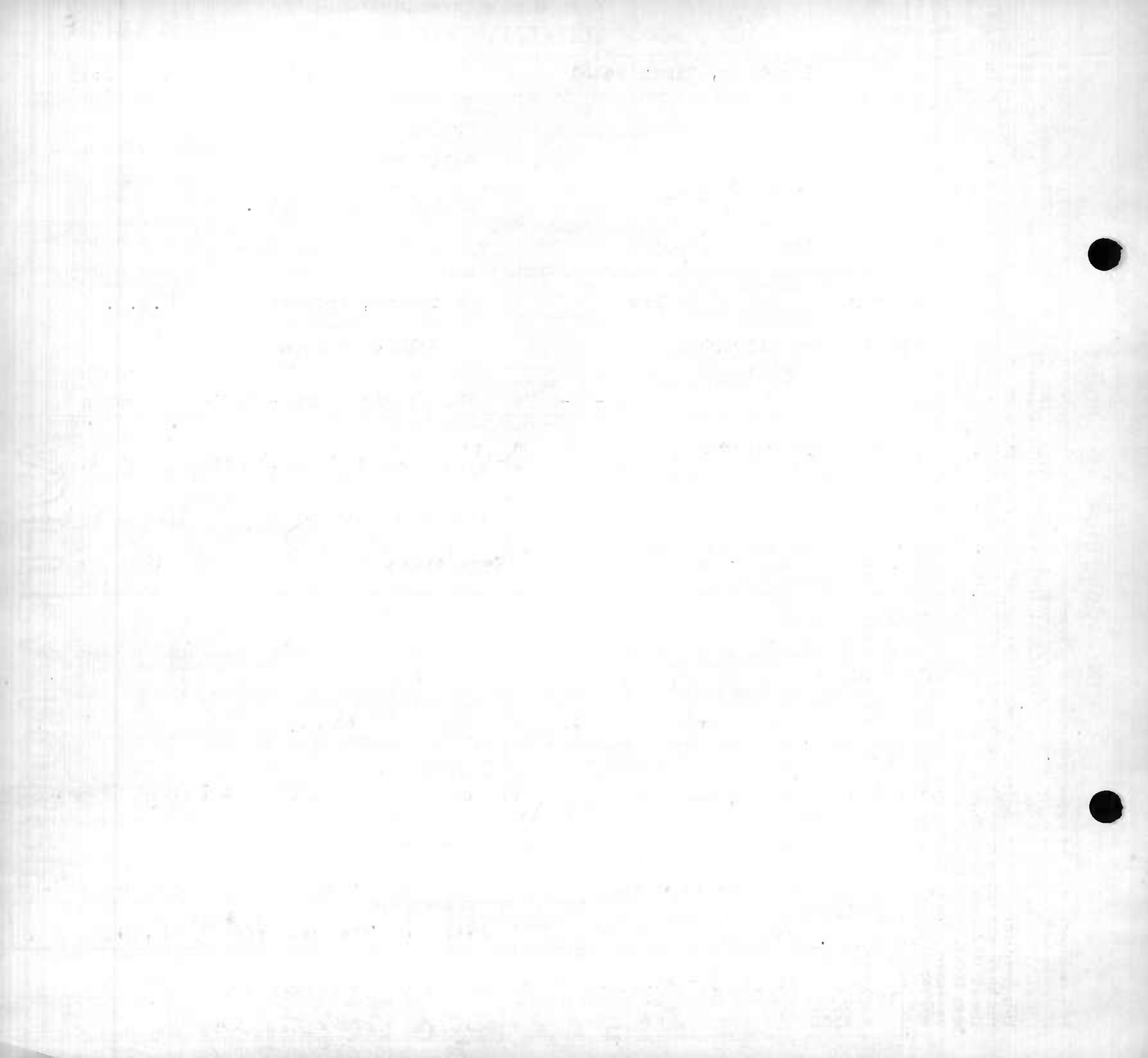
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65-13402 | |
|--|------------------------------|--|-------------------------------------|---|--|
| BIRTH NO. 65-32606 | | 65-13402 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Baley Bay King | | 2. DATE AND HOUR OF DEATH 12-28-65 11¹⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 9-06 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 601 N BROADWAY 21205 Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location) 1905 E 30th ST | | | |
| 5. SEX Male | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 12/28/65 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Joseph King | | 14. MOTHER'S MAIDEN NAME Elaine Lawson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 776 X1 immaturity | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/28 10PM 1965 to 12/28 11¹⁰PM 1965 , that (I) (we) last saw the deceased alive on 12/28 11PM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nina Vann | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) NINA VANN | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | 24B. DATE 12-29-65 | 24C. NAME of CEMETERY or CREMATORY JOHNS HOPKINS HOSPITAL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, 12, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Farquhar | | 25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13403 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13403 | |
|--|------------------|--|------------------------------|--|-------------------------------|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Silverberg, Simon Nobel | | 2. DATE AND HOUR OF DEATH 12/28/65 6:15 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Keswick Home | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Cambridge Arms Apts. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/4/1883 | 9. AGE (In years lost birthday) 81 years | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer | | 10B. KIND OF BUSINESS OR INDUSTRY Law | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel Simon Silverberg | | | | 14. MOTHER'S MAIDEN NAME Goldie Johnson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-38-9870 | | 17. INFORMANT ADDRESS The Keswick Home - Medical Records | | | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Sufficient of urinary tract origin DUE TO (B) Carcinoma lung DUE TO (C) Atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 12 days Approx 6 days 10 yrs | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (A.P.P.R.O.X.) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? None | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 14 JAN 1965 to 28 DEC 1965, that (I) (we) last saw the deceased alive on 28 DEC 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Aubrey D. Richardson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 28 DEC 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Aubrey D. Richardson | | | | 23D. ADDRESS M.D. Keswick 700 W. 10th St Baltimore 11 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/30/65 | | 24C. NAME OF CEMETERY or CREMATORY ANNA'S SHOLom Cong. | | 24D. LOCATION (City, town, or county) (State) ROSEDALE Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Fickens | | 25C. FUNERAL DIRECTOR ADDRESS Jack Keen's Inc. 2100 EUTAW PLACE BALTO. CITY Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|--|---|--|---|
| BIRTH NO. 65 13401 | | DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13404 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Abraham Sherr | | | 2. DATE AND HOUR OF DEATH Dec 28, 1965 9:58 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Hospital General Hosp. Baltimore, Md. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore Maryland B. COUNTY 14-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1701 Eutaw Place Apt 9 AB | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ? | 8. DATE OF BIRTH 6/95 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner | | 10B. KIND OF BUSINESS OR INDUSTRY ? Taylor | | 11. BIRTHPLACE (State or foreign country) Latavia | |
| 13. FATHER'S NAME I. Sherr | | | 14. MOTHER'S MAIDEN NAME ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS hospital chart | |
| 18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) acute pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. chronic lung dis. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald T. Lewers MD | | | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) DONALD T. LEWERS MD | | | | 23D. ADDRESS MARYLAND GENERAL HOSP | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/31/65 | | 24C. NAME of CEMETERY or CREMATORY WORKMAN Circle | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Tack Lewis Inc. 2100 EUTAW BALTO CITY Md. | | | |

Dr. J. H. [illegible]

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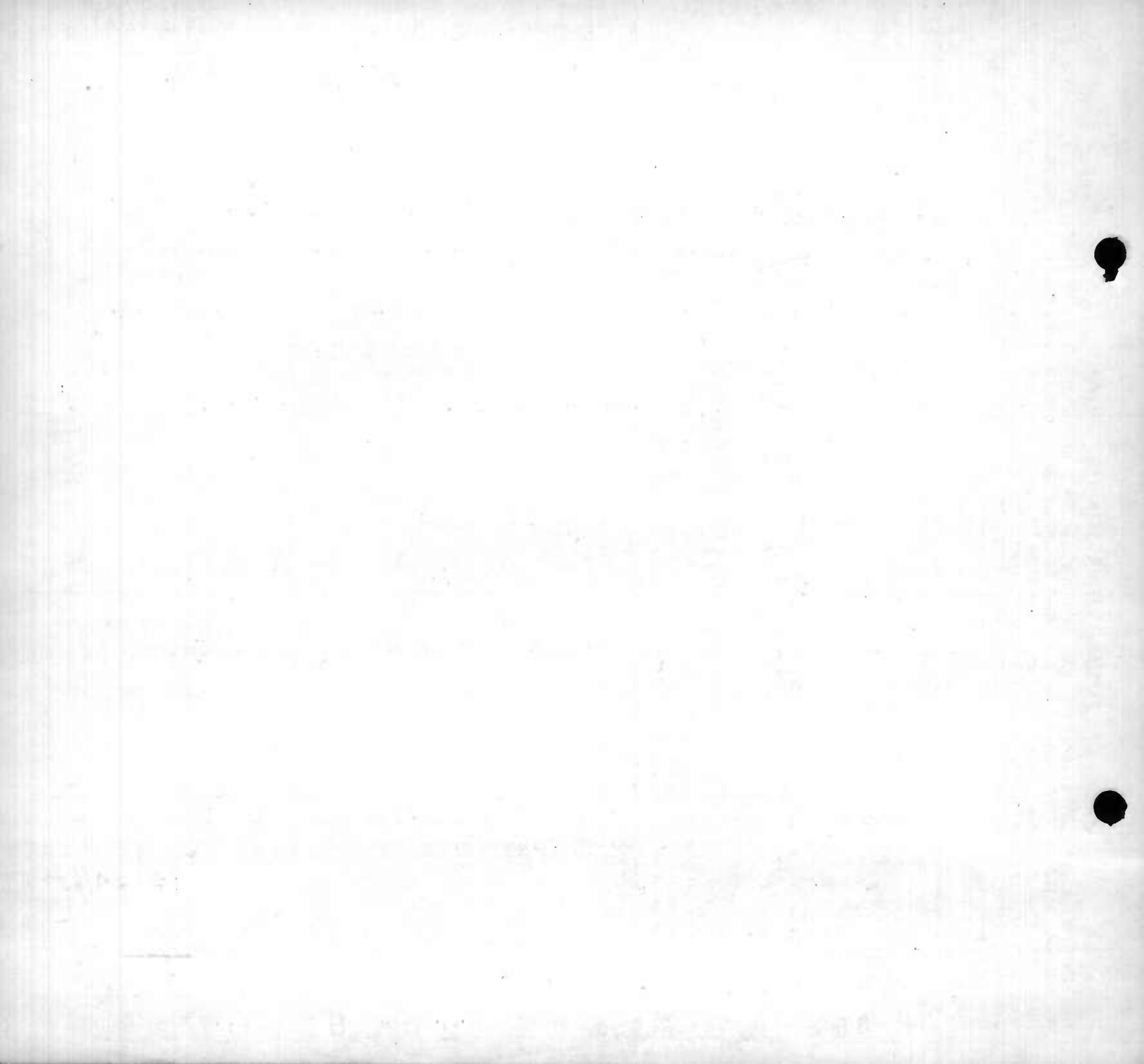
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

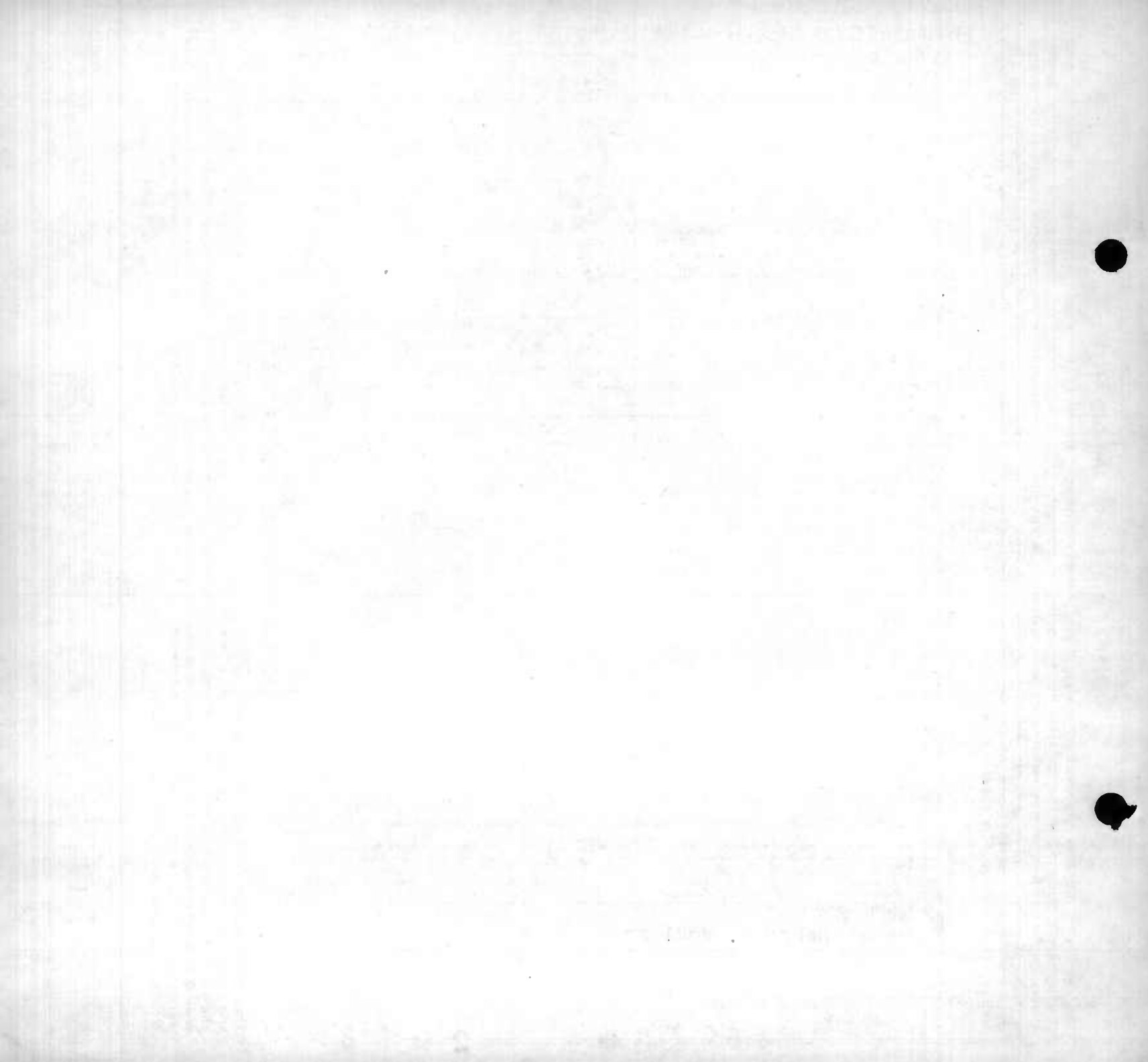
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13405 | |
|---|-------------------------|---|-----------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Figinski, Stephen (STEPHEN FIGINSKI) | | 2. DATE AND HOUR OF DEATH 12/29/65 Sat 1:55 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY HOS | | 1.55 P.M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 2215 Gough Street. | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-1-88 | 9. AGE (In years lost birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY City of Baltimore | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Anthony Figinski | | 14. MOTHER'S MAIDEN NAME Martha Nowicki | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-40-4952 | | 17. INFORMANT ADDRESS Mrs. Emilia Figinski, 2215 Gough St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest | | CAUSE OF DEATH (A) DUE TO Cardiac Arrest | | INTERVAL BETWEEN ONSET AND DEATH At time of death | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Bleeding peptic ulcer 6 days | | | |
| (C) _____ | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Right lower lobe pneumonia 6-7 days | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/23 19 65 to 12/29 19 65 , that (I) (we) last saw the deceased alive on 12/29 1:55 PM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE Jerry S. Dorman | | | | 23B. DATE SIGNED 12/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) Jerry S. Dorman | | 23D. ADDRESS M.D. The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/3/66 | | 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Falsky | | 25C. FUNERAL DIRECTOR ADDRESS M. E. SADOWSKI & SONS, 1808 EASTERN AVE | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13406 | |
|--|----------------------|---|---------------------------------|---|--|
| BIRTH NO. 65 13406 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John Sidney Davis | | 2. DATE AND HOUR OF DEATH 12/24/65 12:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Georgetown C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Penn. Ave 1701 | | | |
| 5. SEX M | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 1/18/94 | 9. AGE (In years lost birthday) 71 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VA. | |
| 13. FATHER'S NAME Dotson DAVIS | | 14. MOTHER'S MAIDEN NAME CAMILLA JEFFERSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Chart | |
| 18. 570.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Sigmoid Volvulus DUE TO (B) Gram-Negative Septisemia DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 12/16/65 12/21/65 12/24/65 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/6/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Volvulus | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 12/6/65 19 to 12/24/65 19, that (1) (we) lost saw the deceased alive on 12/24/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Henry H. Bohlman | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) Henry H. Bohlman | | 23D. ADDRESS University Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary | |
| 24D. LOCATION (City, town, or county) (State) A. A. County, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Feltman | | 25C. FUNERAL DIRECTOR Joseph B. Rock | | ADDRESS 1309 N. Lombard St. | |



65 13407

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13407

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LUCILLE

TYSON

2. DATE AND HOUR PRONOUNCED DEAD

December 27, 1965 6:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1713 Cliftview Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. E982X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple cutting and stabbing wounds
DUE TO of throat, abdomen and chest.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1713 Cliftview Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 27 65

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

stabbed during argument

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-27-65

EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN

3 1966

Robert E. Fisher, M.D.

Joseph B. Rock 1304 N. Central Ave

VALLEY POLICE

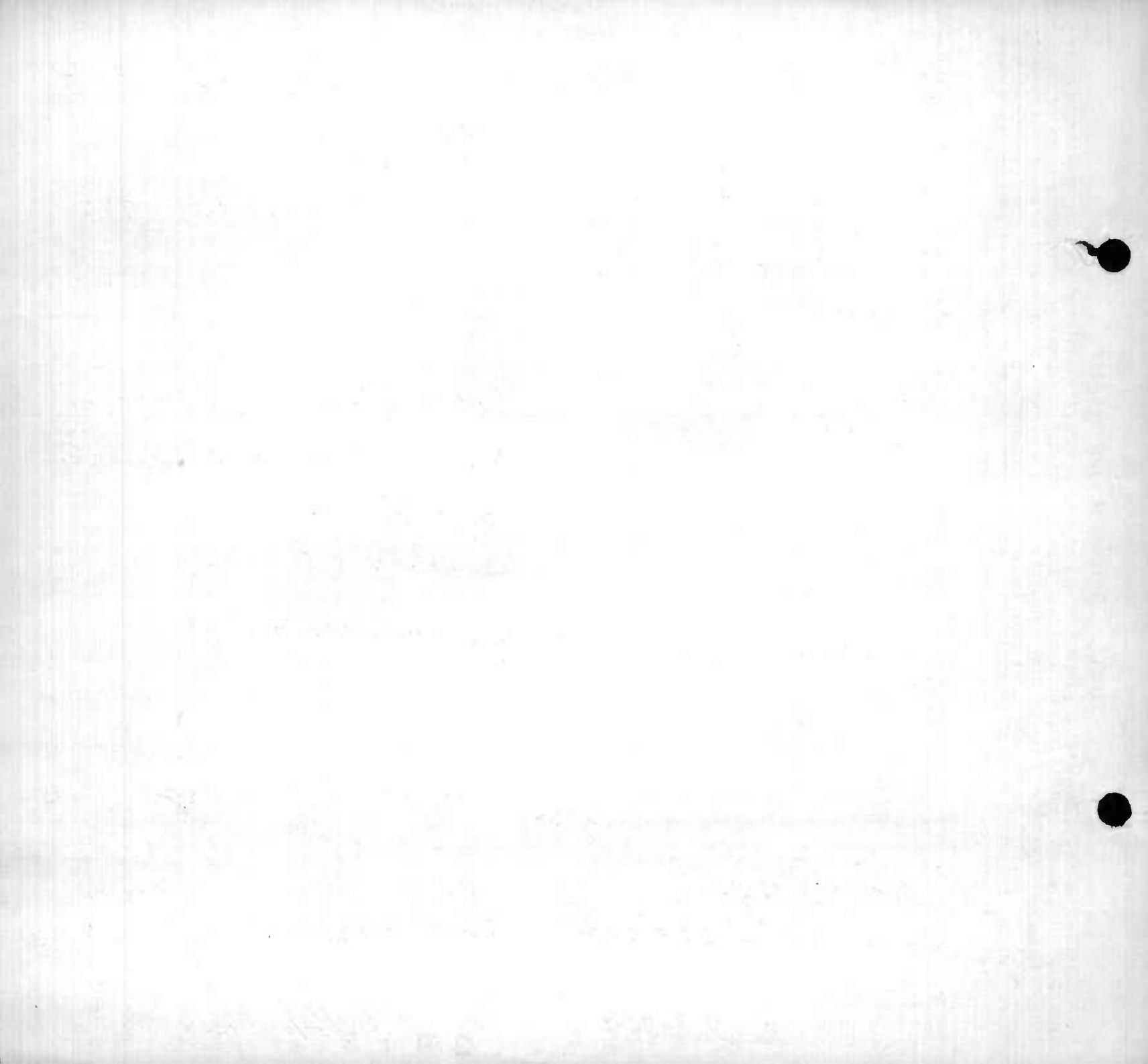
OFFICE

M. M. M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

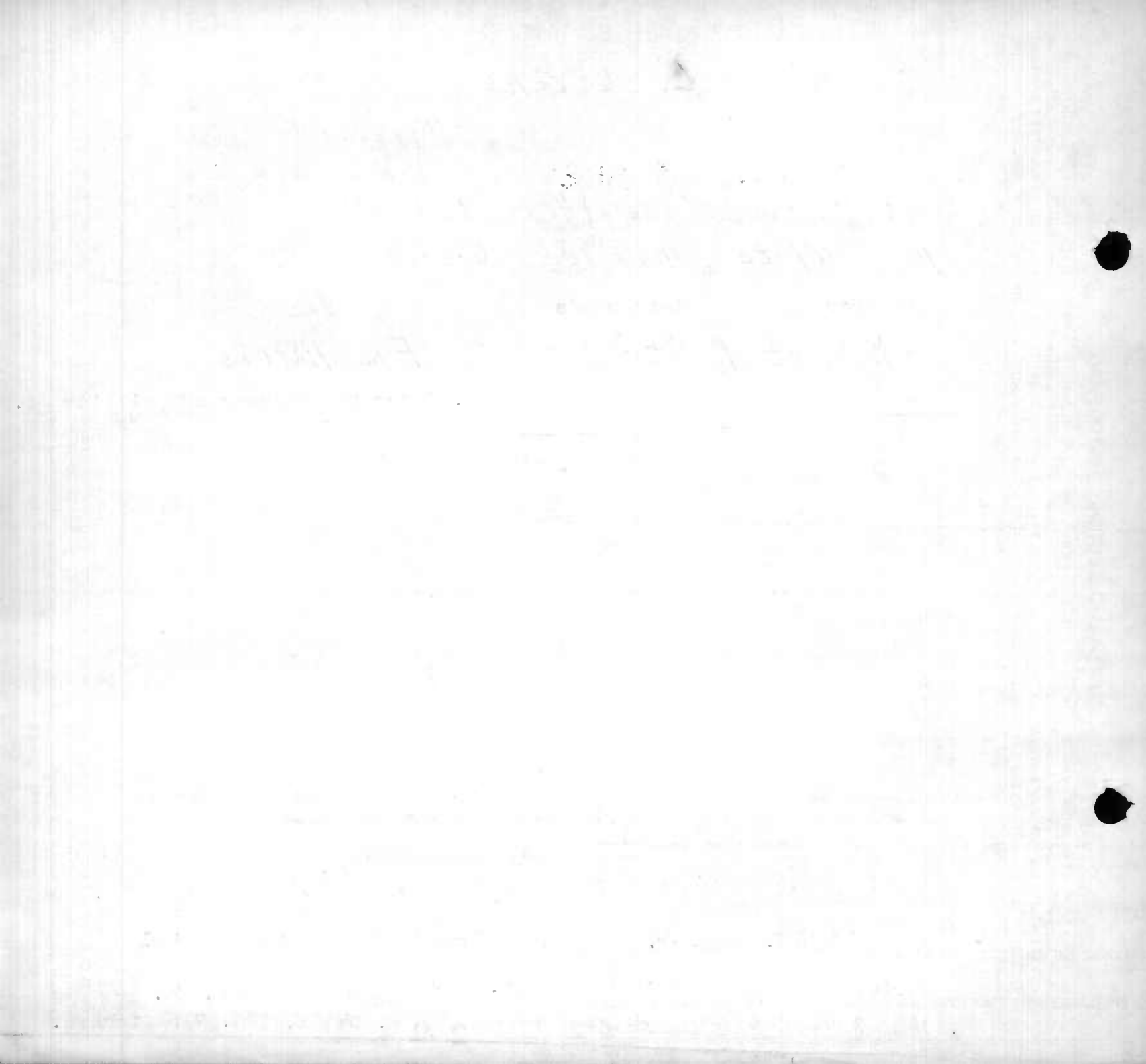
| | | | | | |
|---|----------------------|--|------------------|--|---|
| BIRTH NO. 65 13408 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13408 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>EMMA STANLEY</i> | | 2. DATE AND HOUR OF DEATH <i>12-28-65 3 P. M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>John Hopkins Hosp.</i> | | A. STATE <i>MD</i> B. COUNTY <i>9-08</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO.</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>1310 BONAPARTE AVE</i> | | | |
| 5. SEX <i>F.</i> | 6. RACE <i>C.</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) <i>78</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MD</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>?</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>?</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>William Stanley</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.1 I</i> | | ADDRESS <i>1310 BONAPARTE AVE</i> | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH <i>Crown Thromboses</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO <i>Myocardial</i> | | | |
| | | (B) DUE TO <i>Med. Cardiac Failure</i> | | | |
| | | (C) DUE TO <i>Med. Cardiac Failure</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Hypertension</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Unk.</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/28/65</i> 19 <i>65</i> to <i>12/28</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/28</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Robert R. Reford</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/30/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR ALBERT L. LAFORREST</i> | | 23D. ADDRESS <i>822 N. Bond ST BALTO 21205 MD</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i> | | 24E. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 24F. NAME OF REGISTRAR <i>Robert E. Farley</i> | |
| 24G. FUNERAL DIRECTOR <i>Joseph J. Lock</i> | | 24H. ADDRESS <i>1304 N. Central St.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|--|---|--|-----------------------------|------------------------------|--|
| BIRTH NO. 65 13409 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 13409 | | | | |
| 1. NAME OF DECEASED (Type or Print) Robert L. Stevens | | | | | 2. DATE AND HOUR OF DEATH 12-30-65 10:22 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp. | | | | | A. STATE Maryland B. COUNTY 22-01 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 829 Williams St. | | | | |
| 5. SEX M. | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6-6-08 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10B. KIND OF BUSINESS OR INDUSTRY State roads | | 11. BIRTHPLACE (State or foreign country) Va. | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Robert P. Stevens | | | | | 14. MOTHER'S MAIDEN NAME Eva Harris | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Georgette Stevens 829 William St. | | | | |
| 18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Adenocarcinoma, ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. primary site unknown | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that the (this hospital) attended the deceased from 12-1 19 65 to 12-30 19 65 , that we (we) last saw the deceased alive on 12-30 , 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE C. E. Jones, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 12/30/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Calvin E. Jones, Jr. M.D. | | | | | 23D. ADDRESS South Baltimore General Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/3/66 | | 24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Park | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | 25B. NAME OF REGISTRAR Robert E. Farber | | | 25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 Light St | | | |



65 13410

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13410

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (BOBBY)

ROBERT LEE BREWSTER

2. DATE AND HOUR PRONOUNCED DEAD

December 31, 1965 1:14 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Harford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Belcamp

D. STREET ADDRESS (If rural, give location)

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CERTIFICATE AMENDED
Johns Hopkins Hospital
1-17-66

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Apr. 21, 1918

9. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Assembler

10B. KIND OF BUSINESS OR INDUSTRY

Shoe

11. BIRTHPLACE (State or foreign country)

Richlands, Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.,

13. FATHER'S NAME

John Brewster

14. MOTHER'S MAIDEN NAME

Stella Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

229-64-2449

17. INFORMANT

Curtis E. Brewster, Box 12, Belcamp, Md.,

ADDRESS

21017

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Head and neck injuries
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Route 7 west of Route 24

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12-31-65 12:30 A.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

auto-auto collision (passenger)

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-31-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

1/1/66

23C. NAME of CEMETERY or CREMATORY

Hurst-Scott F.H.,

23D. LOCATION

(City, town, or county)

Richlands, Tazwell, Virginia

24A. DATE REC'D BY HEALTH DEPT.

JAN

3 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Howard K. Mc Comas & Son, Abingdon, Md.,

ADDRESS

Good Certificate of Registration

[Signature]

65 13411

BALTIMORE CITY HEALTH DEPARTMENT

65 13411

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DANIEL MACKERY

2. DATE AND HOUR PRONOUNCED DEAD

December 28, 1965 2:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1235 Division Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Oct. 1919

9. AGE (in years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEEL WORKER

10B. KIND OF BUSINESS OR INDUSTRY

SHIP YARD

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Mackery

14. MOTHER'S MAIDEN NAME

Effie Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

220-10-6522

17. INFORMANT

Hospital Records

ADDRESS

Baltimore, Md.

18.

410X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Inactive rheumatic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-28-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-1-66

23C. NAME OF CEMETERY or CREMATORY

Paradise Cemetery

23D. LOCATION

(City, town, or county)

Trappe

(State)

MD

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

Robert E. Fisk

24C. FUNERAL DIRECTOR

James B. Washell, Easton, Md.

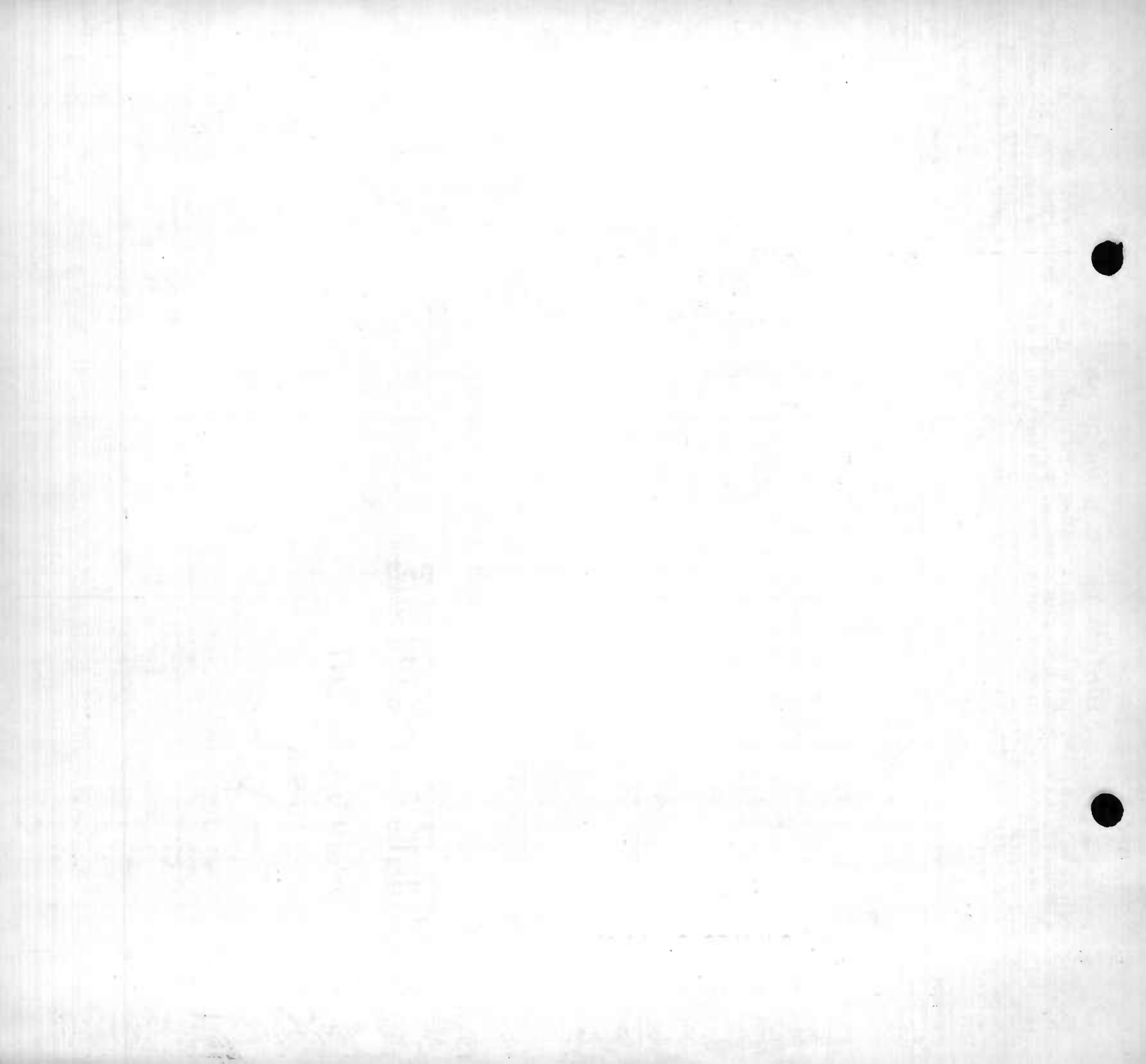
ADDRESS

WALLACE JOHNSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|----------------------------|
| 65 13412 | | CERTIFICATE OF DEATH | | 65 13412 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | GEORGE J. KRAUSSER | | 12/28/65 7:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| UNION MEMORIAL HOSPITAL | | M.D. | | BALTIMORE | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | COCKEYSVILLE (RURAL) | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | HAPPY HOLLOW ROAD 53-00 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| MALE | WHITE | SINGLE | 10/22/82 | 83 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| FARMER (RET) | | SELF EMPLOYED | | M.D. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S.A. | | JOHN KRAUSSER | | SUSANNA GILBRINGER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| UNK | | | | IRMA BRYANT (SISTER) 1939 QUENTIN RD DUNDALK, MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | A. CEREBRAL VASCULAR ACC. | | 7 DAYS | |
| ANTECEDENT CAUSES | | B. DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | C. DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/21 1965 to 12/28 1965, that (I) (we) last saw the deceased alive on 12/28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Charles S. Brown M.D. | | | | 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| DR. CHARLES S. BROWN | | M.D. UNION MEMORIAL HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | DEC. 31, 1965 | | LOUDON PARK CEMETERY | |
| | | | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 3 1966 | | Robert S. Johnson | | John Burns' Son, Towson, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|---------|--|---------------------|
| BIRTH NO. 65 13413 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | Registered No. 65 13413 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| ALBERT DOBBINS | | December 30, 1965 7:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | |
| | | B. COUNTY | |
| SOUTH BALTIMORE GENERAL HOSPITAL 1213 Light Street Baltimore, Md. 21230 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | BALTIMORE | |
| D. STREET ADDRESS (If rural, give location) | | 922 Light Street #21230 | |
| | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| MALE | WHITE | SINGLE | JANUARY 29, 1911 54 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| N ONE | | B ALTIMORE | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| WILLIAM DOBBINS | | MARY GAYHART | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Yes # 2 | | Family | |
| 17. INFORMANT | | ADDRESS | |
| | | Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | |
| ANTECEDENT CAUSES | | (B) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 2 | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21F. HOW DID INJURY OCCUR? | |
| | | | |
| 22. I certify that (X) (this hospital) attended the deceased from December 28, 19 65 to December 30, 19 65, that (X) (we) last saw the deceased alive on December 30, 19 65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| Dr. M. Kaufman | | 12-31-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| Dr. M. Kaufman | | SOUTH BALTIMORE GENERAL HOSPITAL 1213 Light Street Baltimore, Md. 21230 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Burial | | 1 3 65 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Cedar Hill | | Brooklyn, A. A. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| JAN 3 1966 Robert E. Farkas | | 25C. FUNERAL DIRECTOR | |
| | | Mc Gully | |
| | | ADDRESS | |
| | | 130 E. Fort Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 13414 | |
|---|------------------|--|-----------------------------------|---|------------------------------|
| BIRTH NO. 65 13414 | | CERTIFICATE OF DEATH | | Registered No. 65 13414 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>LENA L. MEYERS</i> | | 2. DATE AND HOUR OF DEATH <i>12/29/65 5:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>25-04</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>3510 Fourth St.</i> | | D. STREET ADDRESS (If rural, give location) <i>3510 4th St.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Ohio</i> | |
| 5. SEX <i>F.</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>2/4/85</i> | 9. AGE (In years last birthday) <i>80</i> | 12. CITIZEN OF WHAT COUNTRY? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Smith</i> | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Family - Same</i> | | ADDRESS | |
| 18. <i>578X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Anemia, severe</i> DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Gastrointestinal Bleeding</i> DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Arteriosclerotic CVD with atrial fibrillation</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 24 1962</i> to <i>December 24 1965</i> , that (I) was lost saw the deceased alive on <i>December 29 1965</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE <i>Morton M. Krigger</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>Dec. 30, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Morton M. Krigger</i> | | 23D. ADDRESS M.D. <i>5010A Ritchie Hwy.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/1/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Cem Elbridge</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>McCully</i> | |
| 25C. FUNERAL DIRECTOR <i>McCully</i> | | ADDRESS <i>737 Patterson Ave</i> | | | |

1/4 of 1/2
1/2 of 1/2
1/2 of 1/2

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1/2 of 1/2
1/2 of 1/2
1/2 of 1/2

65 13415

BALTIMORE CITY HEALTH DEPARTMENT

65 13415

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MELVINA ELIZABETH (GUNBY) GUMBY

2. DATE AND HOUR PRONOUNCED DEAD

December 30, 1965 2:25 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1506 W. Lanvale Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

July 22, 1887

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Speaks

14. MOTHER'S MAIDEN NAME

Mary Hammond

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Evelyn Norris 1506 W Lanvale

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/30/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/3/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

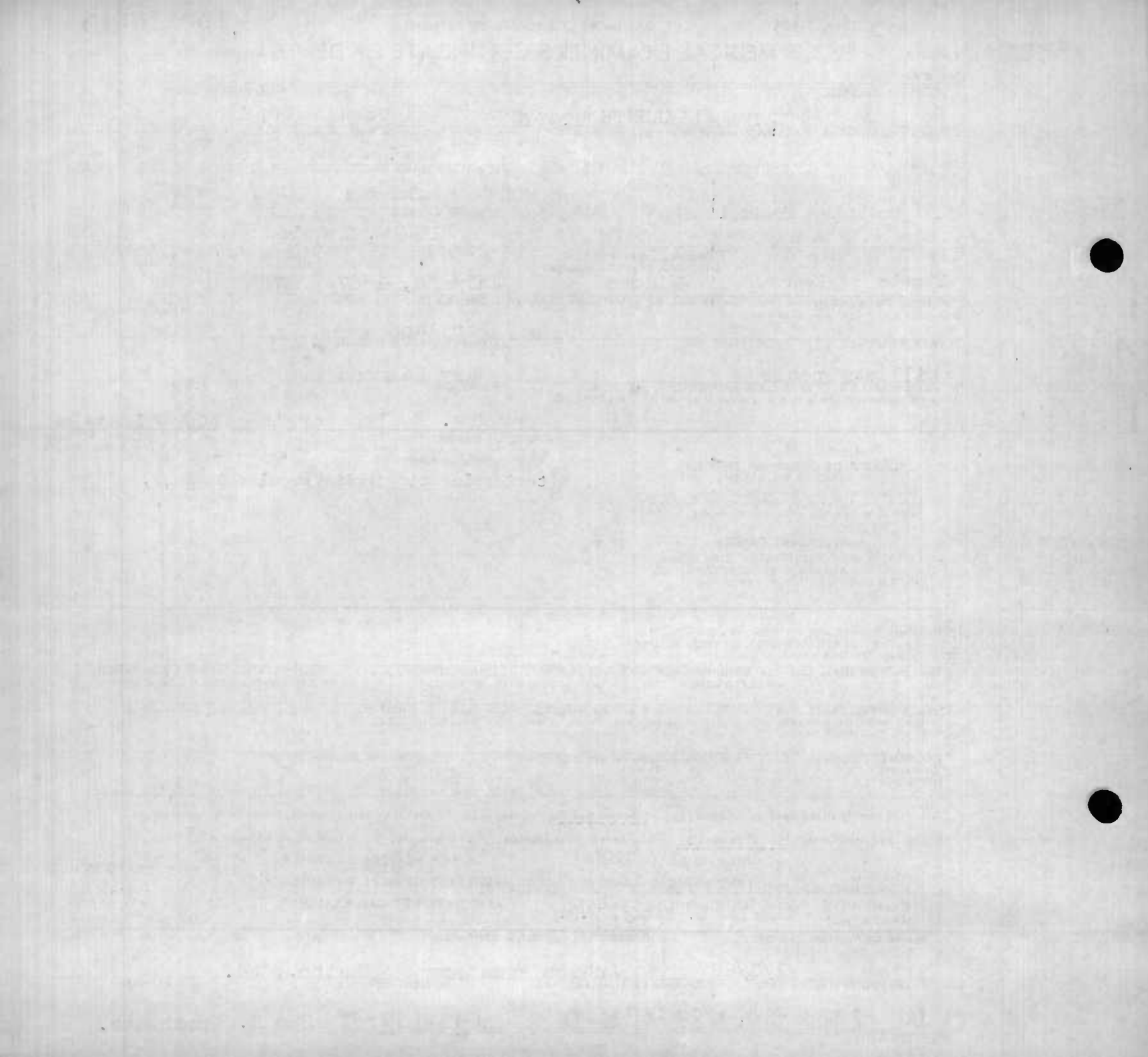
ADDRESS

JAN 3 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

928 E. North Ave.



BIRTH NO. 65 13416
63-18841

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 13416

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KENNETH

L.

SEMONE

2. DATE AND HOUR PRONOUNCED DEAD

December 29, 1965

4:55 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)
 4-1-66
 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2532 Washington Boulevard

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single-Infant

8. DATE OF BIRTH

19
July 17, 639. AGE (In years
last birthday)

2

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Roy Semone

14. MOTHER'S MAIDEN NAME

Jane C. Reese

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL
SECURITY NO.
none

17. INFORMANT

Roy Semone, Father

ADDRESS

2532 Washington Blvd Balto Md 21230

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Anaphylactic Reaction to Penicillin

(A) ~~Acute Tracheitis, Bronchitis and~~~~Early Bronchopneumonia~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Acute Tracheitis, Bronchitis and Early
Bronchopneumonia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH?21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Doctor's Office

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

3914 Park Heights Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 29 65 m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Overwhelming allergic reaction to Peni-
cillin

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/30/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Mon
Jan 3, 1966

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

Brooklyn A A Co Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

1400 S Charles St Baltimore Md
21230

Letter from M.E. 's Office

4-1-66 M.H.

VALLEY FORGE

1935

65 13417

BALTIMORE CITY HEALTH DEPARTMENT

65 13417

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GLENN R. SHAFFER

2. DATE AND HOUR PRONOUNCED DEAD

December 29, 1965 11:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2-25-66

3800 St. Margaret St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3800 St. Margaret St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

May 26, 1920

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bartender

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW II

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

18. 443 X 1 322.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute Alcoholism

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/3/66

23C. NAME of CEMETERY or CREMATORY

Baltimore Natl Cem

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

McLuely 237 Latrobe Ave Md

ADDRESS

Letter from M.E.'s office 2-25-66 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13418 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13418 | |
|--|-----------|--|--------------------------|---|----------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Helen Mc Cann | | | | 2. DATE AND HOUR OF DEATH 12/30/65 7:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 145 S. Linwood #24 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9/14/00 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HARRY COBE | | | | 14. MOTHER'S MAIDEN NAME ROSE BLAIR | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 138-03-8568 | | 17. INFORMANT Mrs. Geraldine Portner | | ADDRESS 1 Glenwood Rd Baltimore 21, Md | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 0 | | | | CAUSE OF DEATH (A) DUE TO Anemia (B) DUE TO Possible embolization to lungs (C) DUE TO Metastatic Cervical Carcinoma Deep femoral & popliteal thrombosis | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/16 19 65 to 12/30 19 65, that (I) (we) lost saw the deceased alive on 12/31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Barry Portner M.D. | | | | 23B. DATE SIGNED 12/30/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) BARRY PORTNER M.D. | | | | 23D. ADDRESS Sinai Hospital | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-3-66 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Feltman | | 25C. FUNERAL DIRECTOR John J. Quinn & Son | | ADDRESS 23, Ind | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-------------------------------------|---|--|
| BIRTH NO. 65 13419 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13419 | |
| 1. NAME OF DECEASED (Type or Print) EVANS BABY GIRL | | 2. DATE AND HOUR OF DEATH DECEMBER 30, 1965 4:00P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 901 BARDSWELL ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) INFANT | 8. DATE OF BIRTH 12-30-65 | 9. AGE (In years last birthday) 2 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 2 20 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME JOHN EVANS | | | |
| 14. MOTHER'S MAIDEN NAME JOSEPHINE BORYS | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL WILKENS AND CATON AVENUE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 776X I CAUSE OF DEATH (A) DUE TO Immaturity (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 30 1965 to DECEMBER 30 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 30 1965 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fe' L. Rubin | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) FE' L. RUBIN | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-31-65 | | 24C. NAME of CEMETERY or CREMATORY HOLY ROSARY CEMETERY DUNDALK | |
| 24D. LOCATION (City, town, or county) (State) MD. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS WEBER FUNERAL HOME 5311 EDMONDSON AVE | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

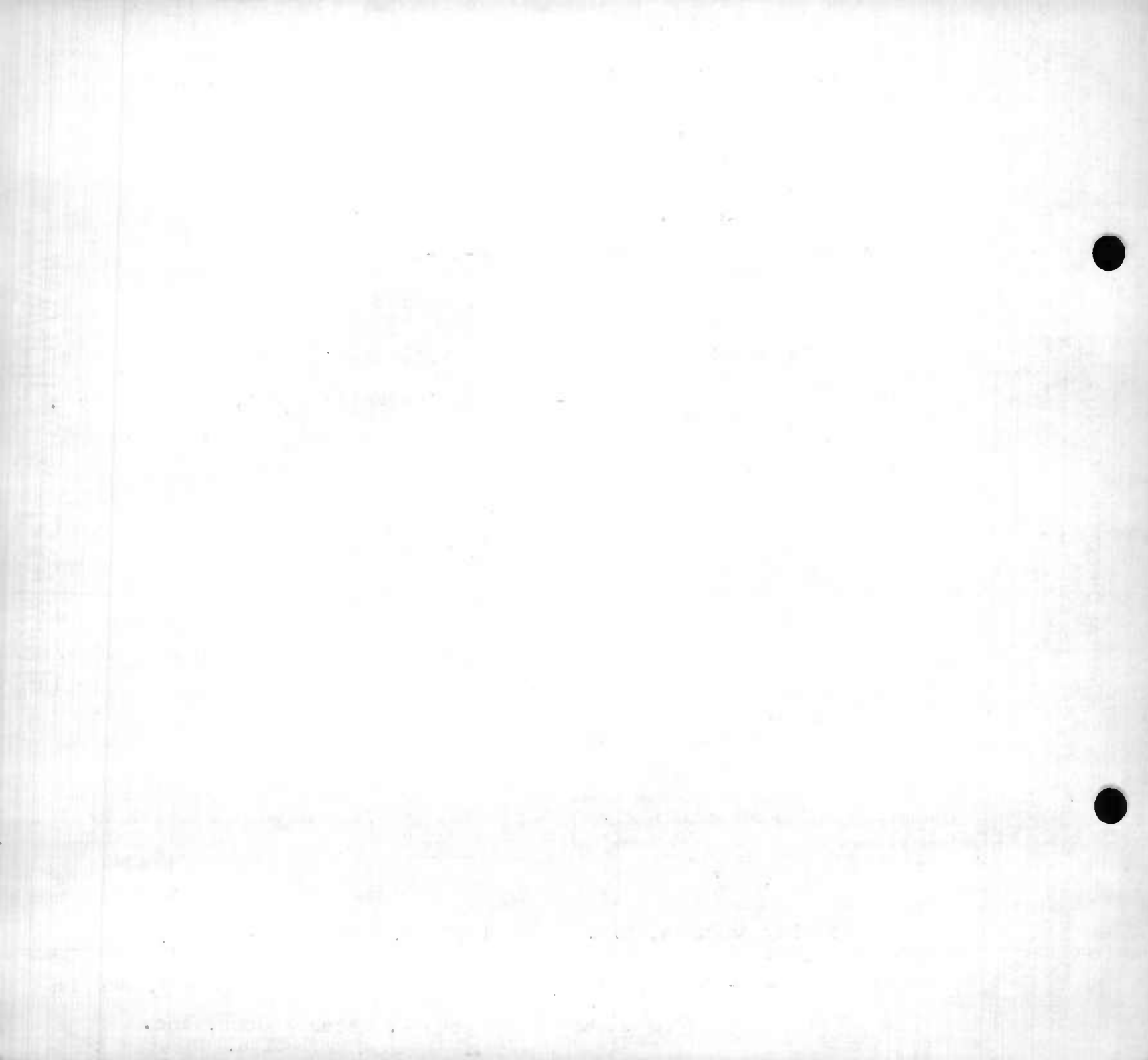
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|-------------------------|---|--|---|---|
| 65 13420 | | CERTIFICATE OF DEATH | | 65 13420 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | KAROL GAECKI GREEKI | | 28 DEC. 65 1:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hosp.</i> | | | | A. STATE <i>MD</i> | |
| | | | | B. COUNTY <i>2-01</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>320 S. CHESTER ST. 21231</i> | |
| 5. SEX <i>male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | 8. DATE OF BIRTH <i>Aug. 24, 1891</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>tailoring</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>clothing & tailoring</i> | | 11. BIRTHPLACE (State or foreign country) <i>Poland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | 13. FATHER'S NAME | | | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <i>21-09-4665</i> | | 17. INFORMANT <i>ANN GREEKI</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>451X I</i> | | ADDRESS <i>320 S. CHESTER ST</i> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) DUE TO <i>rupture of Abdominal Aortic Artery</i> (B) DUE TO <i>Myocardial Infarction</i> (C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>28 Dec 65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Abdominal aortic Aneurysm</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec 25</i> 19 <i>65</i> to <i>28 Dec</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>28 Dec</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>J. M. Hippolito</i> | | | | 23B. DATE SIGNED <i>28 Dec 65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>J. M. HIPOLITO</i> | | | | 23D. ADDRESS <i>Bon Secours Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>1-3-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>HOLY ROSARY CEMETERY</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE CO MD</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Paul E. Farber</i> | | 25C. FUNERAL DIRECTOR <i>JOHN M. WEBER & SONS INC</i> | | | |
| 25D. ADDRESS <i>401 S. CHESTER ST</i> | | | | | |

Bureau 1-3-68 Mr. R. G. Gandy
The Washington Post

FUNERAL DIRECTOR: IMPORTANT

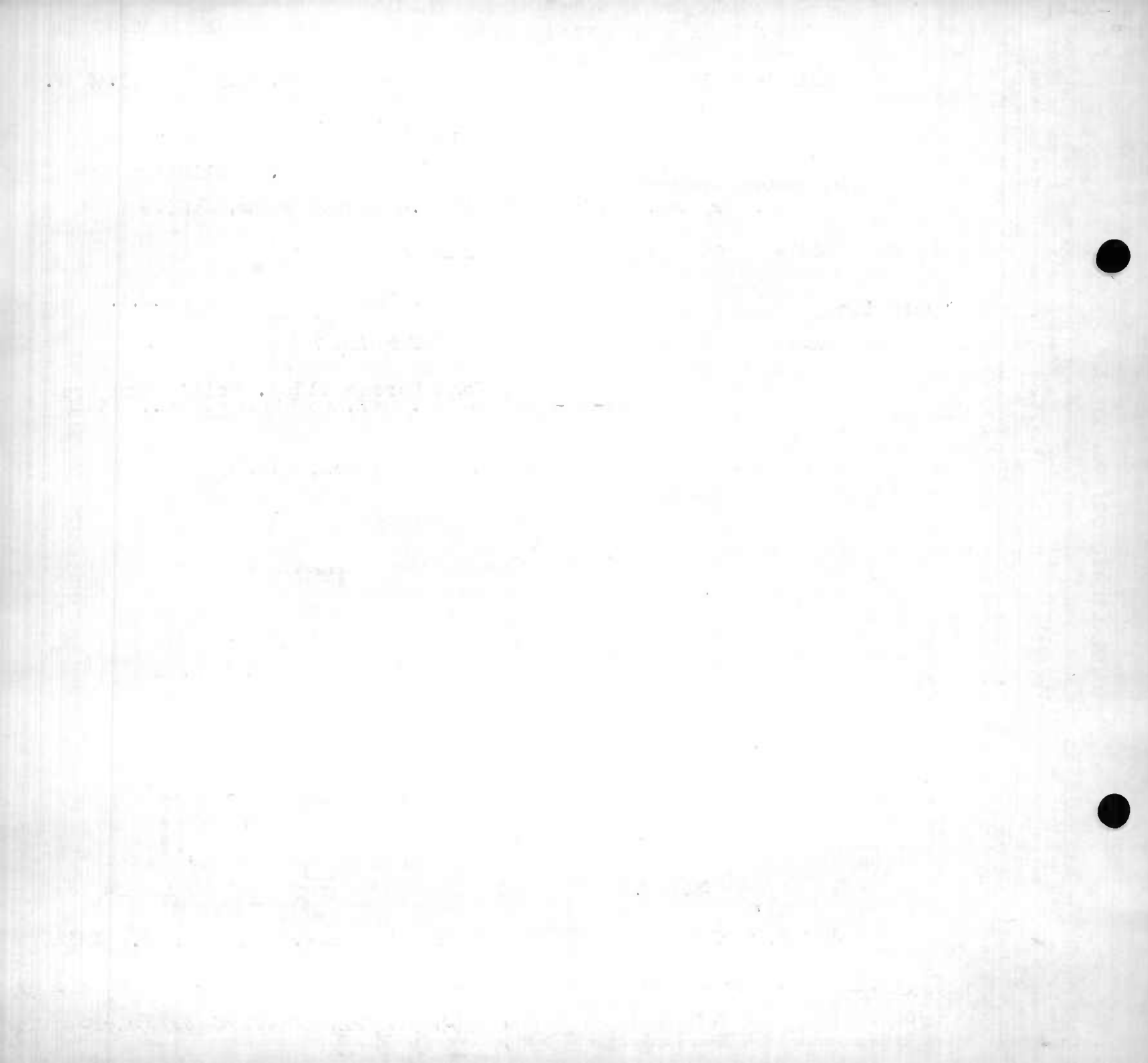
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|---|---|--|---|
| 65 13421 | | CERTIFICATE OF DEATH | | 65 13421 | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Henryk Maliszewski | | | December 30, 1965 7:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 237 McCurley Street Baltimore, Maryland | | | Maryland 20-17 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 237 McCurley Street | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Male | White | Widowed | 3-18-1900 | 65 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Poland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Ignacy Maliszewski | | | Maria Wisniewski | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 217-52-7075 | | Julian Maliszewski, 237 McCurley St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO Pulmonary edema (B) DUE TO Chronic congestive heart failure (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to Dec. 30 19 65, that (I) (we) last saw the deceased alive on Dec. 30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stanley Ankudas, M.D. | | | | 23B. DATE SIGNED 12.30.65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Stanley Ankudas, M.D. | | | | 1802 W. Baltimore Street, 21223 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12-31-65 | | Holy Rosary Cemetery | |
| | | | | Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 3 1966 | | Robert E. Farkas | | John M. Weber & Sons, Inc. 401 S. Chester Street | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

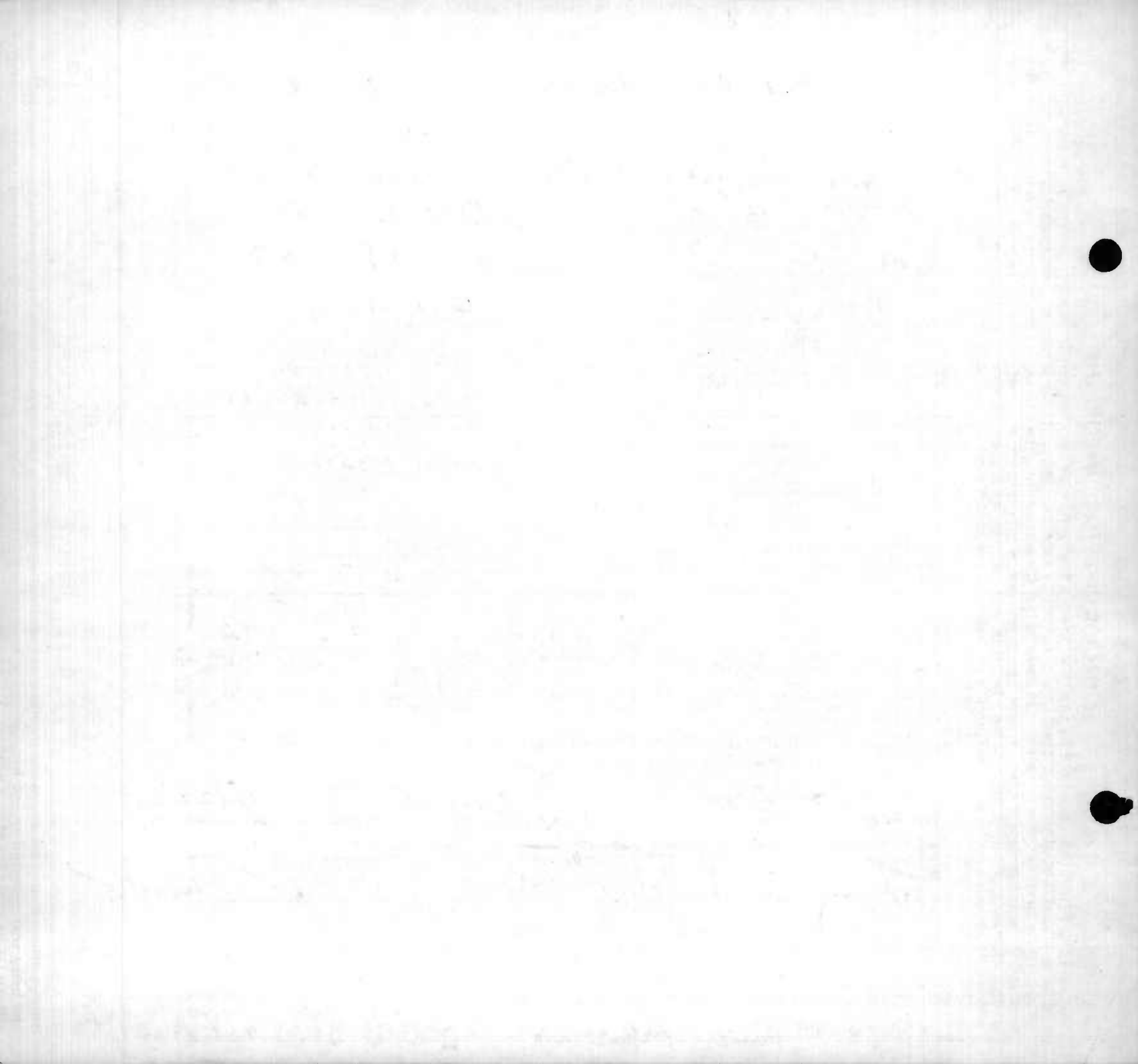
VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

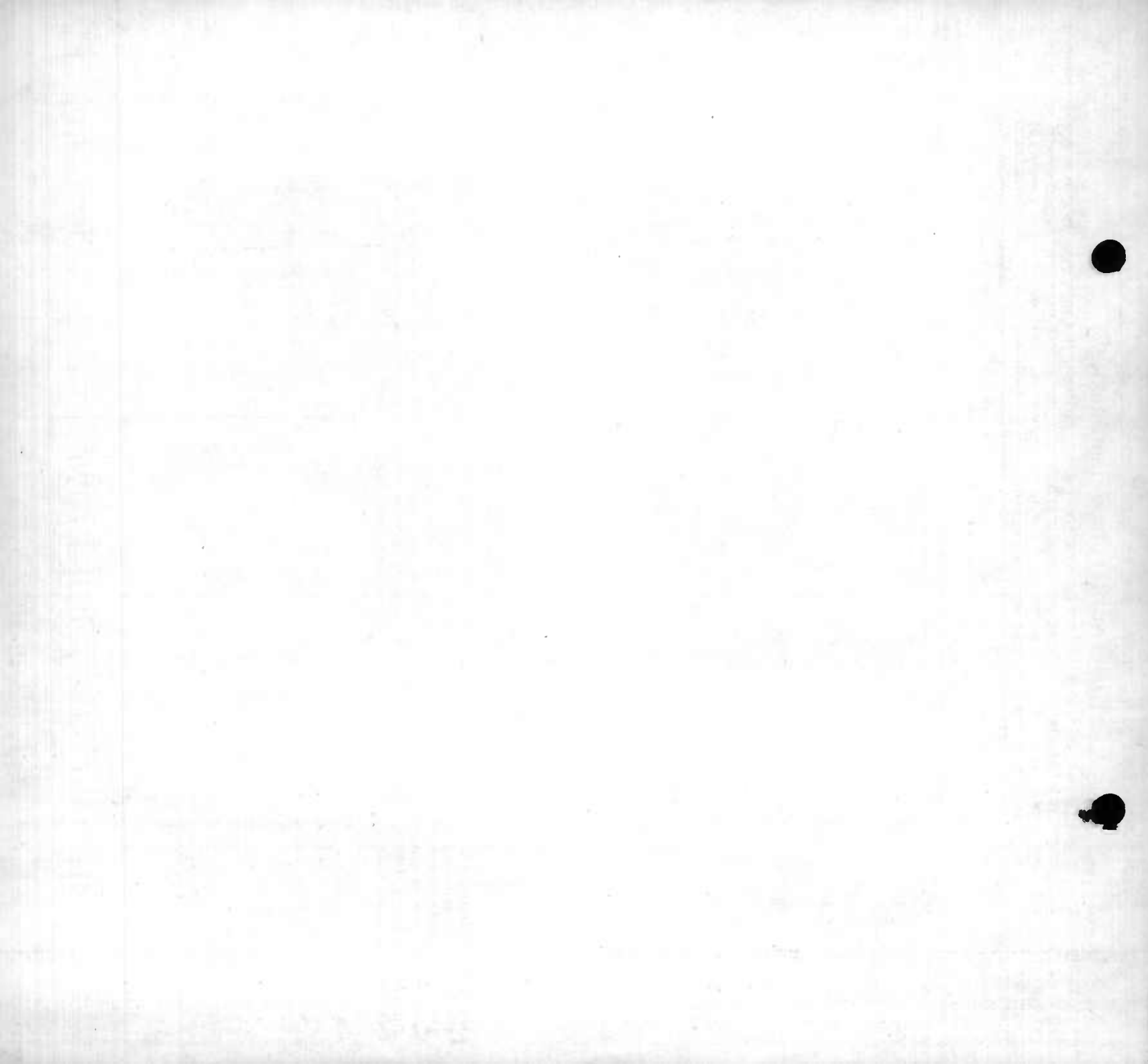
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|--|--|--|----------------------------------|
| 65 13423 | | CERTIFICATE OF DEATH | | 65 13423 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| ELIJAH JONES | | 12-22-65 3:00 A.M. | | | |
| 3. PLACE OF DEATH IN | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| BALTIMORE, MARYLAND | | A. STATE Md B. COUNTY 14-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| SINAI HOSPITAL OF BALTO. BALTO. 15, MD | | BALTO. 17, MD 1710 ETTING ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. AGE (In years lost birthday) |
| M | C | | 2-1-05 | 60 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Thomas Robinson | | Susie Jones | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Matthe Alexander 4023 Belle Ave (sister) | |
| 18. 570.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH - TO BE DETERMINED | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 7 day | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | II Chronic pyelonephritis AS CVN | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that he (this hospital) attended the deceased from 12/22/65 19 to 12/28/65 19 that we last saw the deceased alive on 12/28/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| J. A. Snyder | | 12/28/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | Dec 31/65 | Mt Auburn Cemetery | | Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | ADDRESS | | |
| JAN 3 1966 | Robert E. Johnson | V. Burke Ruggold | 14637 Camp St | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|--------------------------------------|---|---|
| BIRTH NO. 65 13424 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13424 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM COX | | 2. DATE AND HOUR OF DEATH DEC 30 - 1965 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD. B. COUNTY 15604 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSP. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 2214 WALDBROOK AVE | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 7-15-1896 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY STEEL | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME HENRY COX | | 14. MOTHER'S MAIDEN NAME Sylvia | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-10-0597 | | 17. INFORMANT HOSPITAL RECORD ADDRESS | |
| 18. 151X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) CARCINOMA OF STOMACH | | INTERVAL BETWEEN ONSET AND DEATH 3 MOS. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | OSTEO MYELITIS | | 11 MOS. | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 8-27 1965 to 12-30 1965 , that (X) (we) last saw the deceased alive on 12-30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Irving L. Cooperstein | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein | | 23D. ADDRESS M.D. MONTEBELLO STATE HOSP. BALTO. MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL | | 24B. DATE 1/4/66 | | 24C. NAME OF CEMETERY or CREMATORY NEW BETHEL BAPTIST | |
| 24D. LOCATION MEHERRIN VA | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR R. B. S. Jenkins | | 25C. FUNERAL DIRECTOR Franklin R. Rhyne | | | |
| 25D. ADDRESS 638 N. Gilmora St | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VICTOR MARSHALL

2. DATE AND HOUR PRONOUNCED DEAD

December 31, 1965

11:46 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

821 Roundview Road

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Nov 21-1927

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

SCRAP IRON CO

11. BIRTHPLACE (State or foreign country)

ATLANTIC City N.J.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THEODORE MARSHALL

14. MOTHER'S MAIDEN NAME

CORA JACKSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

DOROTHY MARSHALL 821 ROUNDVIEW RD

18.

E 982X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab wound of heart
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, locality, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

679 W. Fayette St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12-31-65 11:25 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed in chest

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-1-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/6/66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

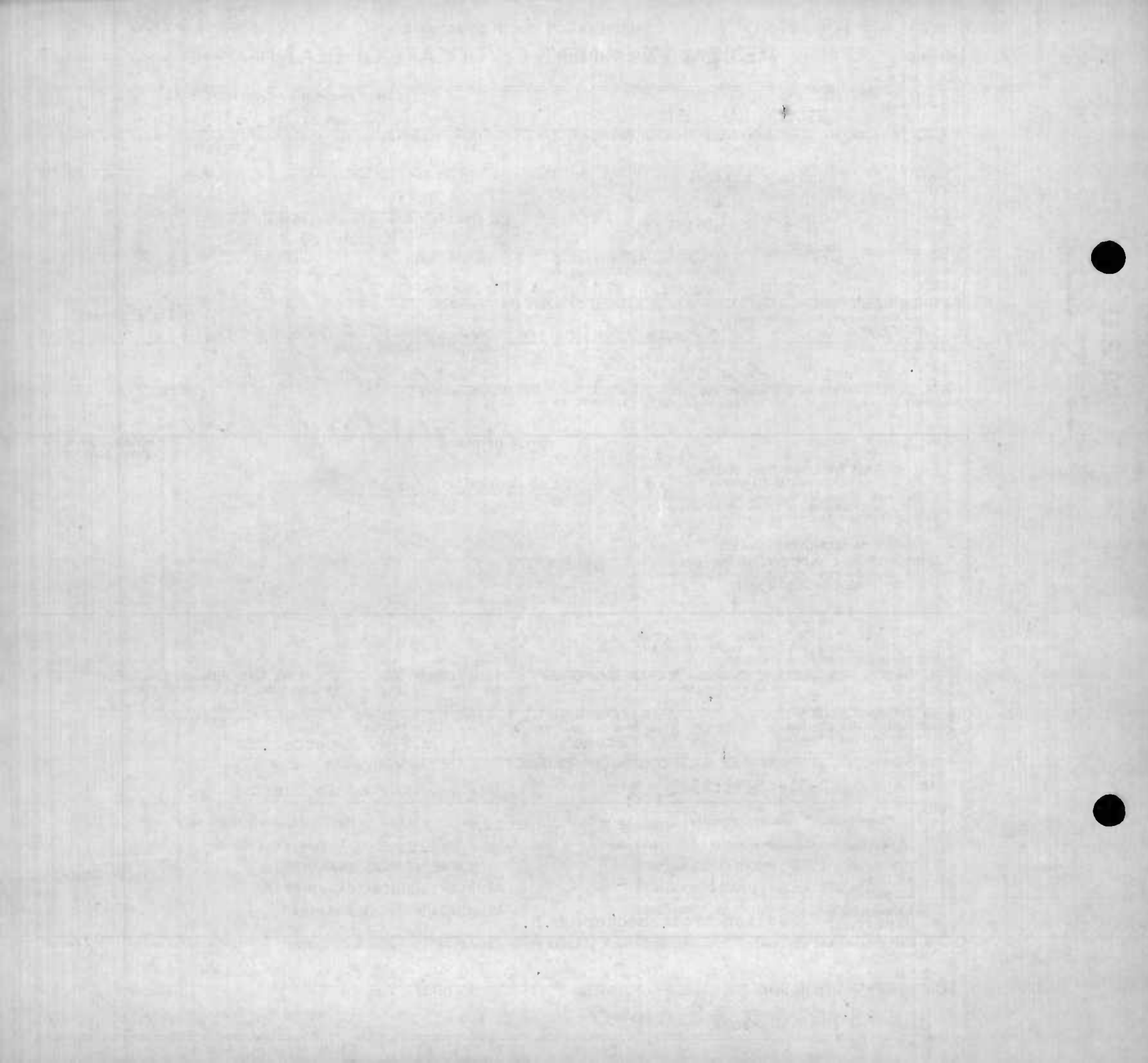
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Margaret R. Hayes 638 N. 6th St

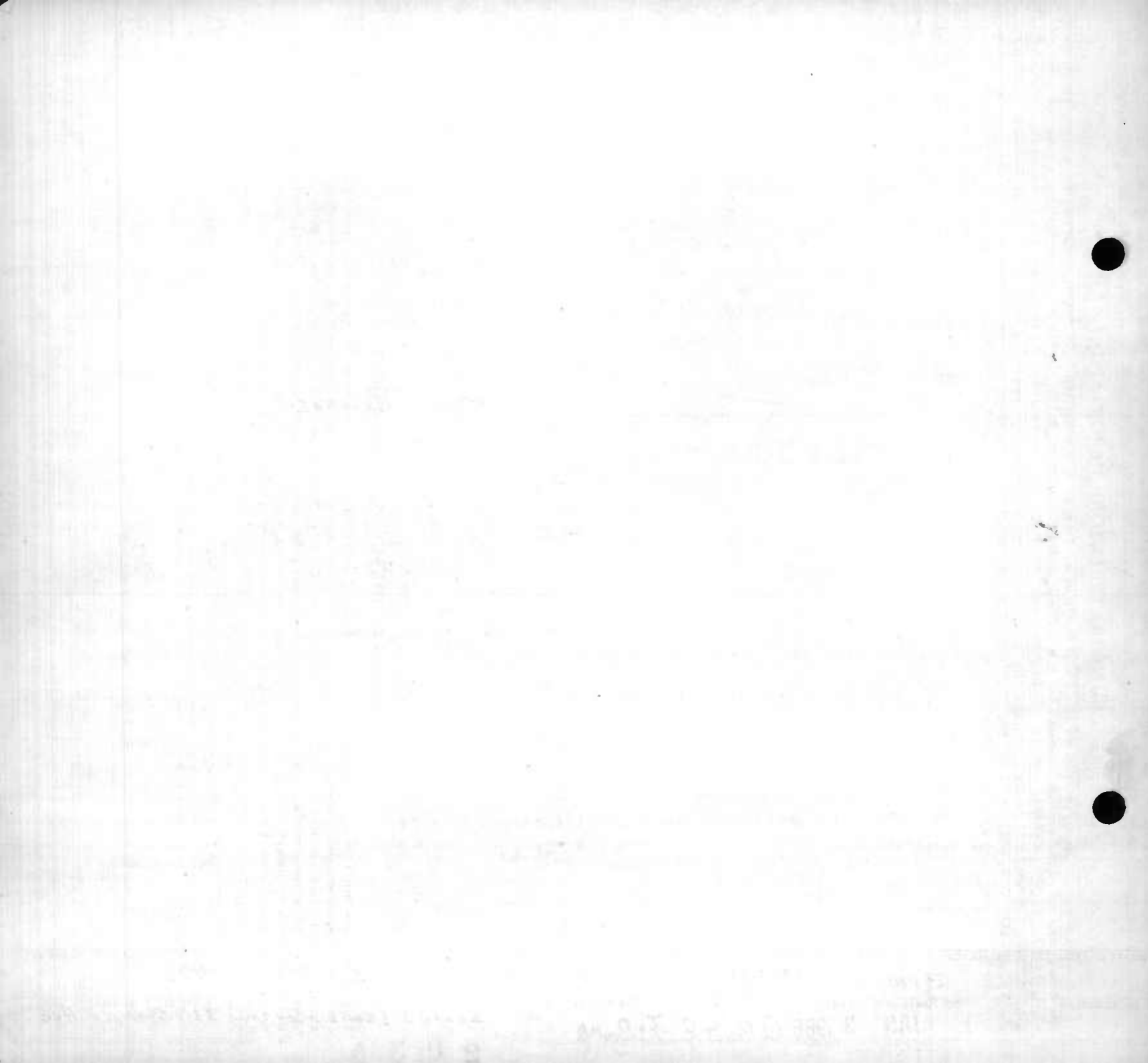
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 13426 | |
|---|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 13426</p> <p>M.E. CASE NO.</p> </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div> <div> <p>1. NAME OF DECEASED (Type or Print) MEYER BLUMENTHAL</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 12-30-65 8:00 A.M.</p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and Hospital</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY 11-03</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) Congress Hotel 306 W. Franklin St.</p> | | |
| <p>5. SEX M</p> | <p>6. RACE CAU</p> | <p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED</p> | <p>8. DATE OF BIRTH 4-10-1883</p> | <p>9. AGE (In years lost birthday) 82</p> | <p>If Under 1 Yr. Months: Days: Hours: Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT INSURANCE</p> | | | <p>11. BIRTHPLACE (State or foreign country) Maryland</p> | | <p>12. CITIZEN OF WHAT COUNTRY? USA</p> |
| <p>13. FATHER'S NAME LEWIS BLUMENTHAL</p> | | | <p>14. MOTHER'S MAIDEN NAME MISS LENA ?</p> | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____</p> | | <p>16. SOCIAL SECURITY NO. _____</p> | <p>17. INFORMANT ADDRESS HOSPITAL RECORDS</p> | | |
| <p>18. 420.1 I CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>(A) DUE TO myocardial infarction</p> <p>(B) DUE TO Coronary Artery Occlusion</p> <p>(C) Arteriosclerotic cardiovascular disease</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>days</p> <p>days</p> <p>years</p> </div> </div> | | | | | |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | |
| <p>19A. DATE OF OPERATION 2</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No) yes</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (APPROX.)</p> | | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 12-27-1965 to 12-30-1965, that (I) (we) last saw the deceased alive on 12-30-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (I) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE J. S. Maizog M.D.</p> | | | <p>23B. DATE SIGNED 12-30-65</p> | | <p>23C. PHYSICIAN'S NAME (Type) J. S. Maizog M.D.</p> |
| <p>23D. ADDRESS Church Home & Hospital</p> | | | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p> | <p>24B. DATE 12/31/1965</p> | <p>24C. NAME OF CEMETERY or CREMATORY SOUTHERN AVE.</p> | | <p>24D. LOCATION (City, town, or county) (State) BALTO. MD</p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966</p> | | <p>25B. NAME OF REGISTRAR Robert E. Feltner</p> | | <p>25C. FUNERAL DIRECTOR ADDRESS SYLVAN S. LEWIS & SON, INC. 3319 OLYMPIA AVE</p> | |



THE BODY OF
ON APPROVAL

Dorzbacher John
FUNERAL DIRECTOR: IMPORTANT

WAS RELEASED
BY L. HIRSCH ME

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|--|--|
| BIRTH NO. 65 13427 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13427 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN Dorzbacher | | 2. DATE AND HOUR OF DEATH 12/26/65 7:30 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY BALTIMORE MD | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5718 MCCORMICK AVE 5300 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX MWLE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED DIVORCED, WIDOWED (specify) MARRIED | 8. DATE OF BIRTH 8/10/98 | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance | | 10B. KIND OF BUSINESS OR INDUSTRY School Board | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOHN Dorzbacher | | 14. MOTHER'S MAIDEN NAME AMELIA ??? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 6-017046 | | 17. INFORMANT Anna Dorzbacher 5718 McCormick Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II HIP FRACTURE CHRONIC ACCIDENTISM | | 19. CAUSE OF DEATH CARDIAC ARREST ASPIRATION PNEUMONIA HIP FRACTURE | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 12/24/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HIP FRACTURE | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5718 MCCORMICK AVE | |
| 21D. TIME OF INJURY (APPROX.) 12/23/65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? FELL FROM BACK PORCH | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/25/1965 to 12/26/1965, that (I) (we) last saw the deceased alive on 12/26/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles Engle | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) CHARLES ENGLE | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-30-1965 | | 24C. NAME OF CEMETERY or CREMATORY Jerusalem Luth. Cemetery | |
| 24D. LOCATION Baltimore | | 24E. (City, town, or county) | | 24F. (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Felt | | 25C. FUNERAL DIRECTOR Lansbury Funeral Home 7401 Belair Road | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

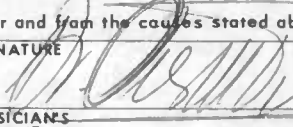
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|--|---|--|--|--|--|--|--|--|--|
| BIRTH NO. 65 13428 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 13428 | | | | |
| 1. NAME OF DECEASED (Type or Print) HOFFELD, MARY J. | | | | | 2. DATE AND HOUR OF DEATH 12-29-65 2:10A M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 28 | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 27 NORTH ROLLING ROAD | | | | | | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED (specify) | | 8. DATE OF BIRTH 12-8-93 | | 9. AGE (In years last birthday) 72 | | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME LEO WALTER | | | | | | 14. MOTHER'S MAIDEN NAME MAGDALENE HERTZ | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVES. | | | | | | | | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) Hypertensive Arteriosclerosis DUE TO (C) Heart Disease INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) No | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 27 19 65 to DECEMBER 29 19 65 , that (I) (we) last saw the deceased alive on DECEMBER 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE <i>J. Harry Truitt</i> | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-29-65 | | |
| 23C. PHYSICIAN'S NAME (Type) J. HARRY TRUITT | | | | | | | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL-CATON & WILKENS AVE. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 12-31-65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | | | | 24D. LOCATION (City, town, or county) (State) Balto. Ind. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Faldut | | | | 25C. FUNERAL DIRECTOR John C. ... | | | | ADDRESS B. F. H. - Catonsville, Ind. | | |

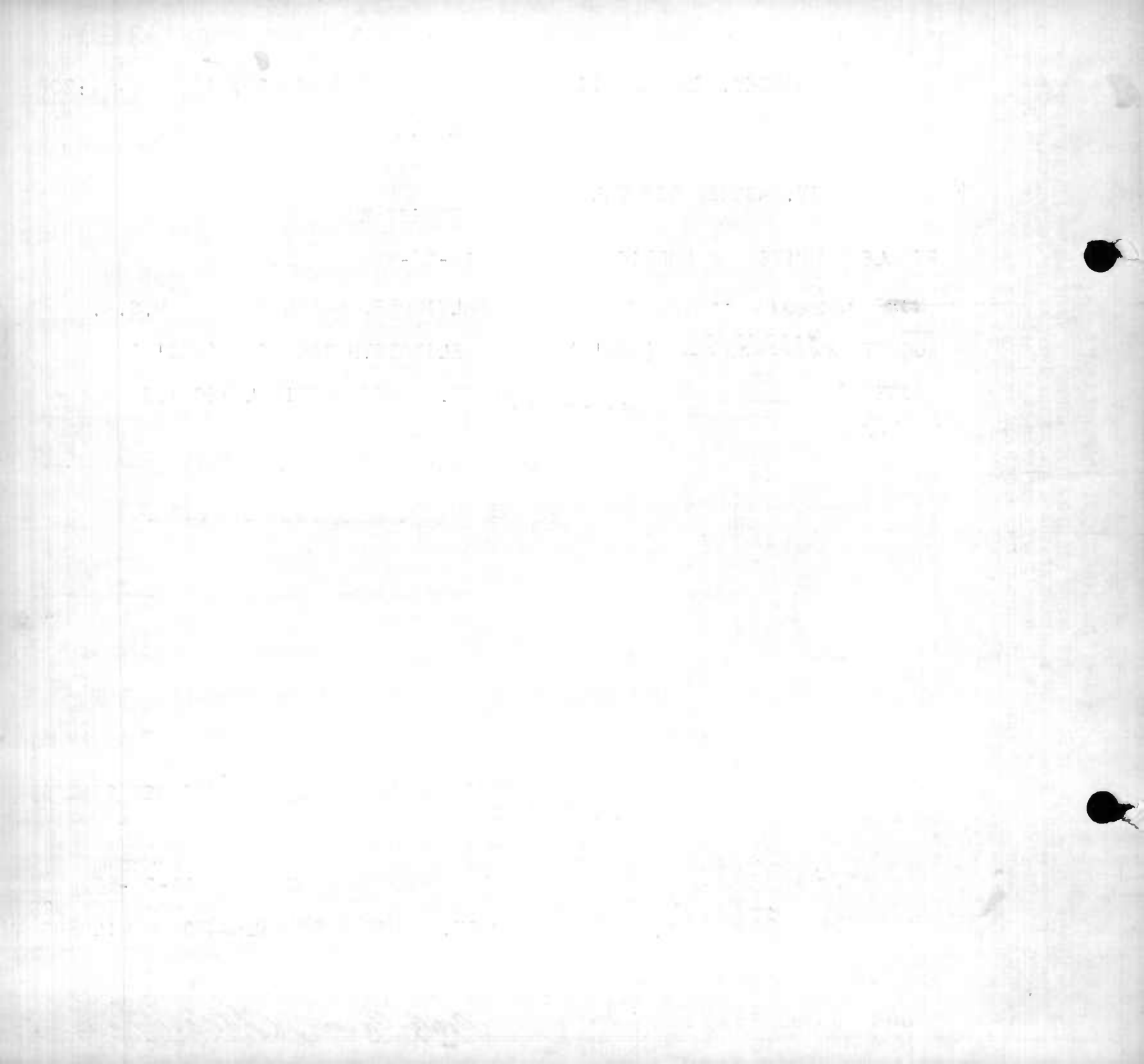
Customs Receipt on Receipt
Hyperborean Hydrographic
Survey Service

John A. Brown
JAN 10 1892

FUNERAL DIRECTOR: IMPORTANT

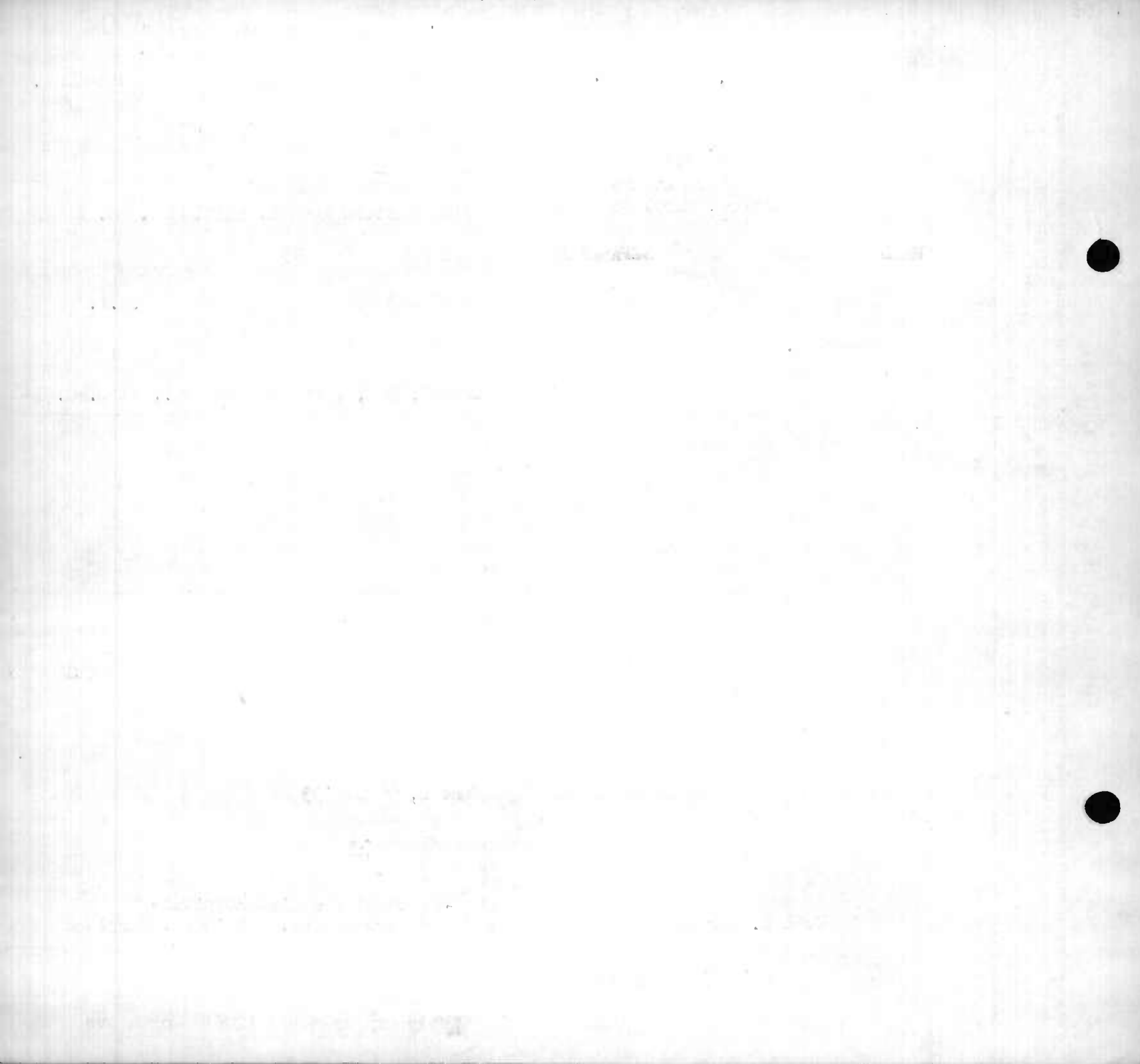
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------|--|---|--|---|--|-------------------------------------|--|--|
| BIRTH NO. 65 13429 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) DORSEY, EMMA MARIE | | | | | 2. DATE AND HOUR OF DEATH DECEMBER 27, 1965 1:20P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | | A. STATE B. COUNTY MARYLAND | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) DORSEY | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) FOREST AVE | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-26-97 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIRE ASSEMBLY | | | 10B. KIND OF BUSINESS OR INDUSTRY UNIFORM CO. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME AUGUST KRONENBERG (DEC'D) | | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH BOETTE (DEC'D) | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE | | | 16. SOCIAL SECURITY NO. 212-24-8757 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS | | | | |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) Generalized Carcinomatosis DUE TO | | | | |
| | | | | | (B) Due To Malignancy Left Breast. - DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DECEMBER 27 19 65 to DECEMBER 27 19 65, that (I) (we) last saw the deceased alive on DECEMBER 27 19 65 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE  M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-27-65 | | |
| 23C. PHYSICIAN'S NAME (Type) PEDRO P. PURCELL | | | | | 23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AV #29 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-30-65 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem Park | | 24D. LOCATION (City, town, or county) (State) Howard County, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13430 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13430 | |
|--|-------------------------|--|------------------------------------|---|----------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) QUEEN, Charles M. | | | | 2. DATE AND HOUR OF DEATH 12/29/65 10:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4940 Eastern Avenue, Baltimore, Md. 21224 | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED | 8. DATE OF BIRTH 6/10/90 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George W. | | | | 14. MOTHER'S MAIDEN NAME Clara Partee | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | | | |
| 18. 731X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. L. middle cerebral art. Thrombosis | | | | (A) DUE TO Pageto Disease of Bone 30 yrs (B) DUE TO Generalized ASCVD & A. fib. 25 yrs (C) Paralytic Agitation 24 yrs | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 6, 1933 to 12-29-1965 , that (I) (we) lost saw the deceased alive on 12-29-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death. | | | | | | | |
| 23A. SIGNATURE John R. Burton | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-29-65 | |
| 23C. PHYSICIAN'S NAME (Type) John R. Burton | | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR John R. Burton | | 25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13431 | | | | BALTIMORE CITY HEALTH DEPT. | | Registered No. 65 13431 | |
|--|-------------------------|---|------------------------------------|---|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Edna Curtis</i> | | | | 2. DATE AND HOUR OF DEATH <i>12.28.65</i> <i>6.55 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore city Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>13-03</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2335 Druid Hill Avenue</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>9.18.92</i> | 9. AGE (In years last birthday) <i>73</i> | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>—</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | |
| 13. FATHER'S NAME <i>Dick Wilson</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Sadie</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT ADDRESS <i>RECORDS: BCH, 4940 Eastern Ave., #21224</i> | | | |
| 18. <i>175.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>uremia</i> DUE TO (B) <i>renal failure</i> DUE TO (C) <i>primary carcinoma of ovary</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>12-14 day</i> <i>12-14 day</i> <i>3-4 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>metastasis to the liver and other abdominal viscera</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>12.6.1965</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>exploratory laparotomy</i> | | 20A. AUTOPSY (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) <i>none</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i> | | | |
| 21D. TIME OF INJURY (APPROX.) <i>—</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>—</i> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>November 11, 1965</i> to <i>November 11, 1965</i> , that (I) (we) last saw the deceased alive on <i>12.28.1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>did not</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Dahman</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12.28.65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>AHMAD DAHMAN</i> | | | | 23D. ADDRESS <i>Baltimore city Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/31/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mt Calvary Cemetry</i> | | 24D. LOCATION (City, town, or county) (State) <i>A A County Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fink</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Adolphus Halstead 1206 W North Ave</i> | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 13432

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

CARTER

2. DATE AND HOUR PRONOUNCED DEAD

December 29, 1965

9:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1005 N. Carrollton Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11/7/12

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Lancaster Va

12. CITIZEN OF
WHAT COUNTRY?
U S A

13. FATHER'S NAME

John W Carter

14. MOTHER'S MAIDEN NAME

Louise

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Nettie Carter 1301 N Carey St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/30/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/3/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

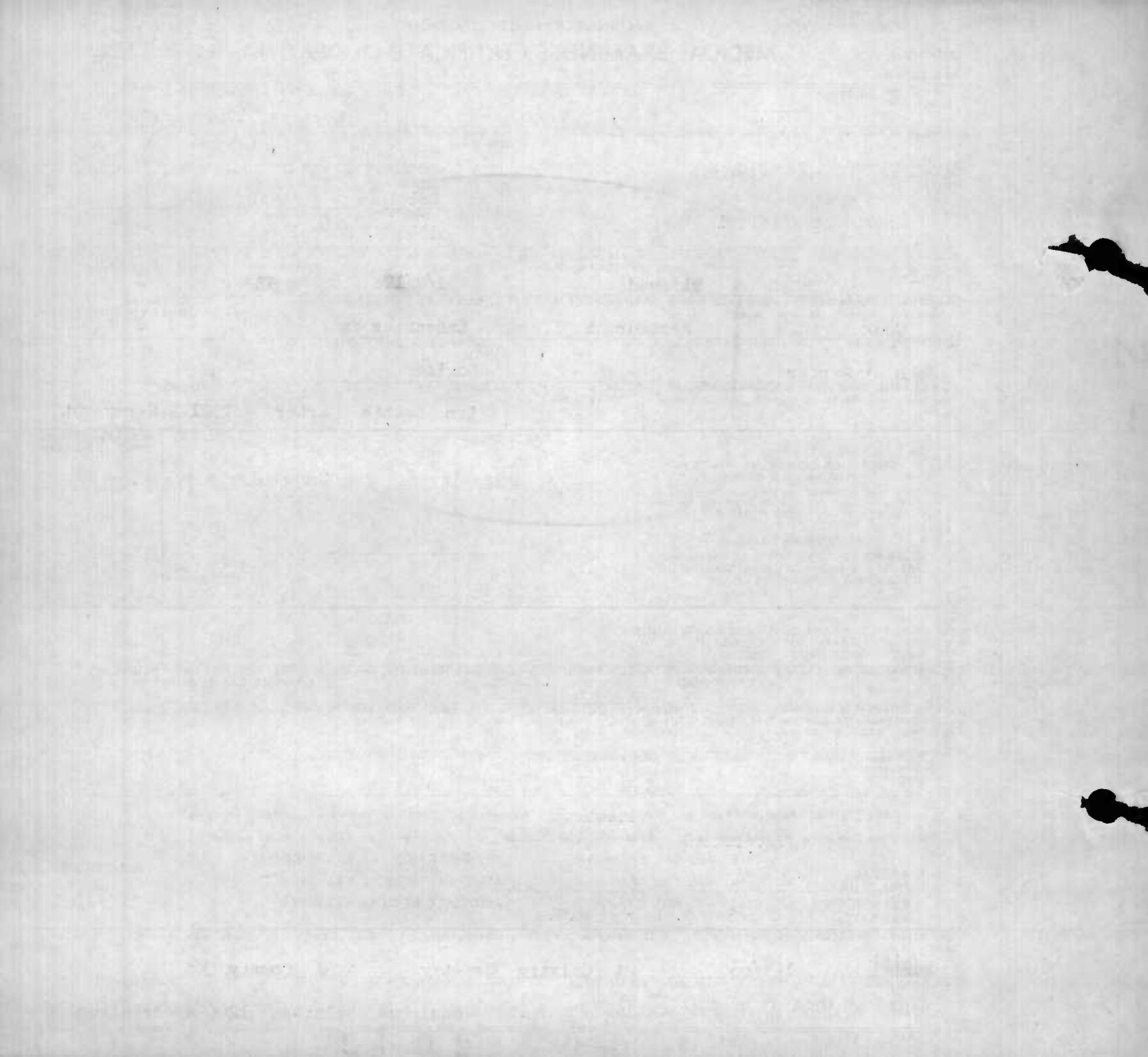
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

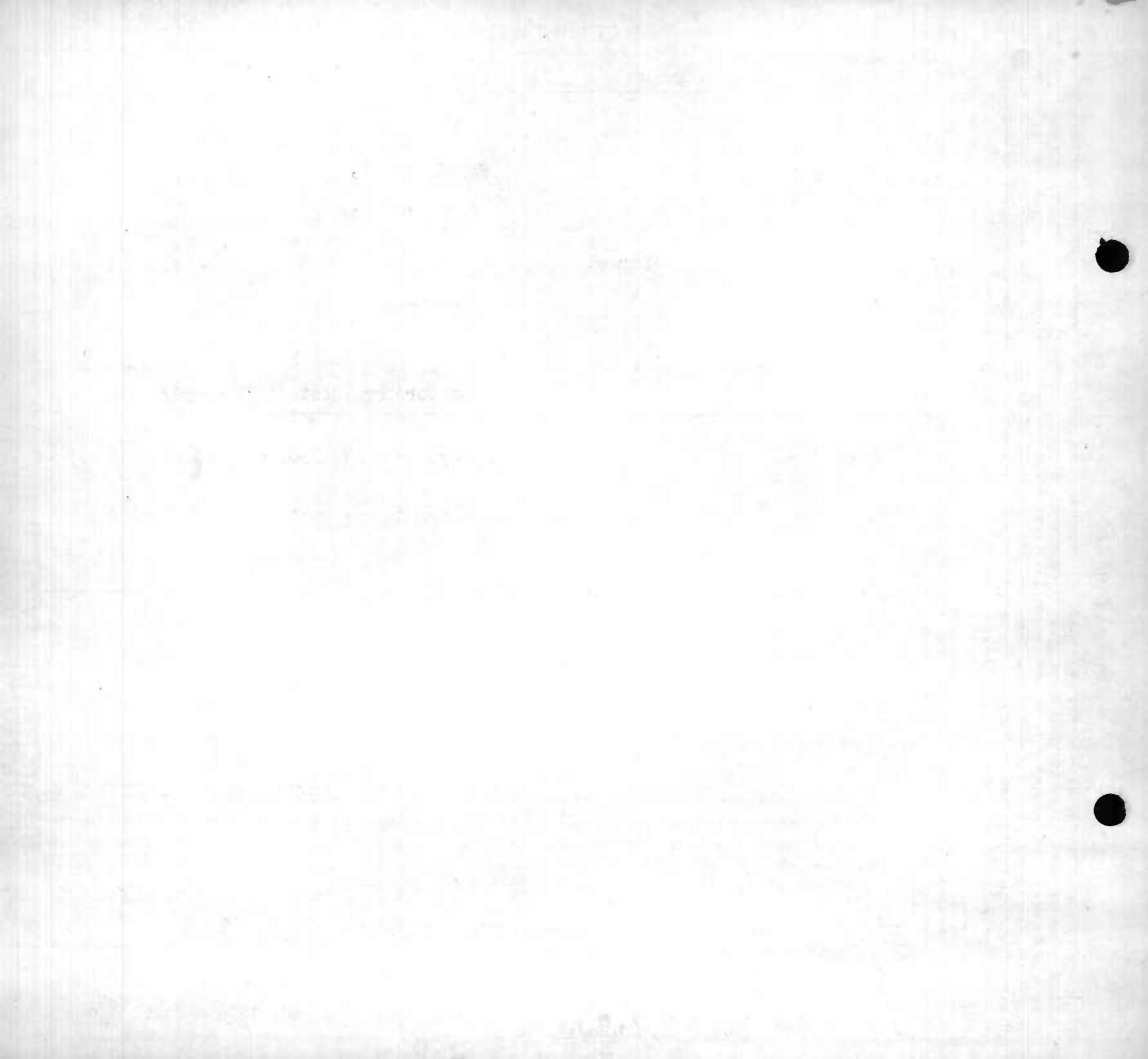
Adolphus Halstead 1206 W North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

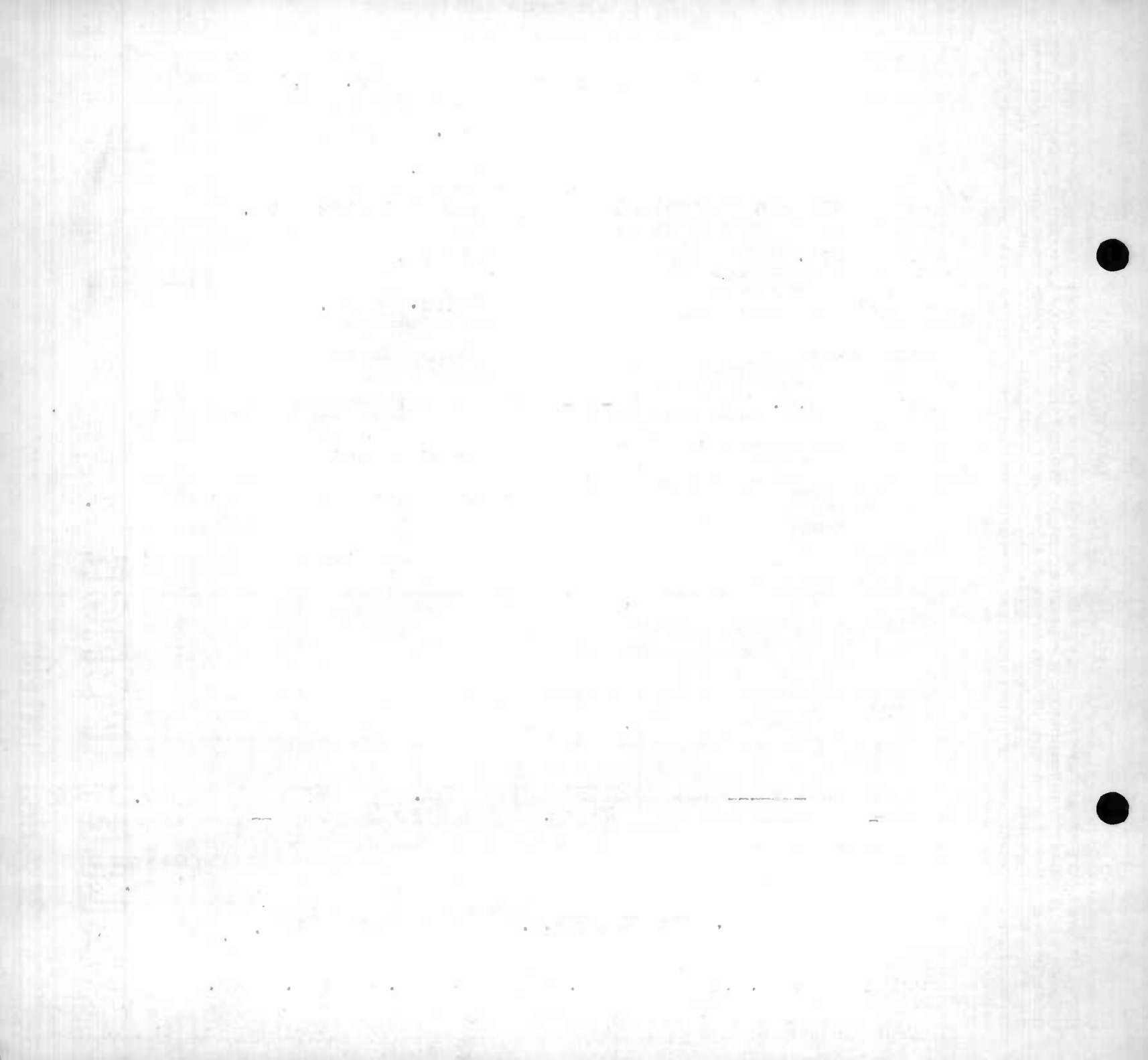
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13433 | |
|--|--|--|--|---|--|
| BIRTH NO. 65 13433 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) MARY CORBIN | |
| 2. DATE AND HOUR OF DEATH December 28, 1965 | | | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) George Washington Carver Nursing Home | | | | A. STATE Md B. COUNTY 19-01 | |
| 5. SEX F | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1, | |
| 6. RACE C | | | | D. STREET ADDRESS (If rural, give location) 607 Penn Ave | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | | B. DATE OF BIRTH ? | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 9. AGE (In years last birthday) 60 | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME ? | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 14. MOTHER'S MAIDEN NAME ? | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS Mrs Dorothy Best 1033 Argyle Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 159X I | | | | CAUSE OF DEATH (A) Gastro-Intestinal Carcinomatosis 6 yrs (B) Parkinson's Disease (C) Gen. Arteriosclerosis | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/16/60 19 60 to 12/28 19 65 , that (I) (we) lost saw the deceased alive on 12/23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E.E. Holt | | | | 23B. DATE SIGNED 12/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) E.E. Holt | | | | 23D. ADDRESS (M.D.) 3715 Liberty Hgts. Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/31/65 | | Mt Calvary Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 3 1966 | | Robert E. Fadden | | Adolphus Halstead 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

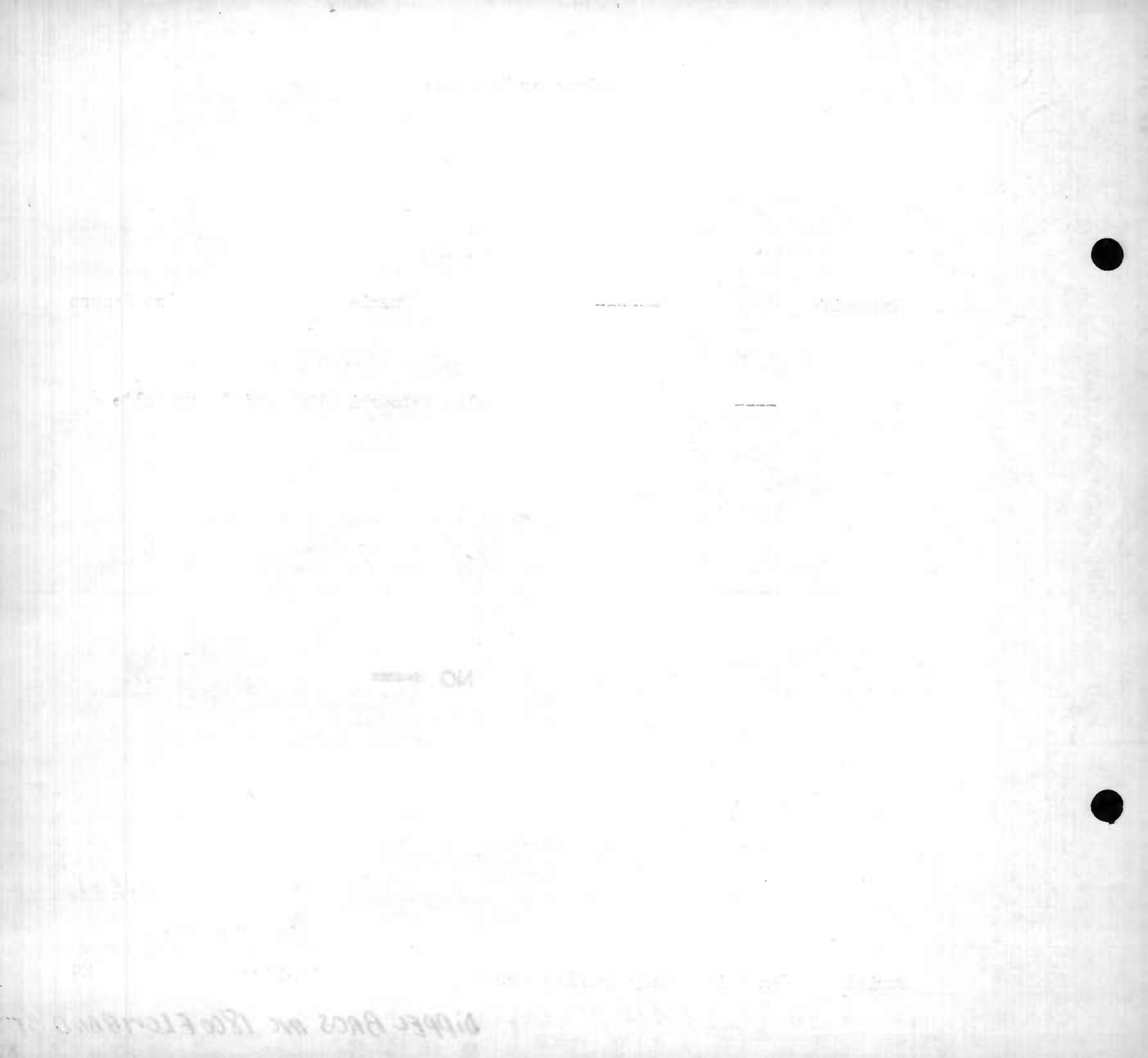
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13434 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13434 | |
|--|--|--|--|---|--|--|--|-----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) | | | | Frank Raymond Howard | | Dec. 29, 1965 | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| Lutheran Hospital | | | | Md. | | 15-38 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | Balto. | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 3405 Fairview Ave. | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | |
| Male | | Col. | | Married | | July 29, 1899 | | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Janitor | | | | | | Balto. Md. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| John Howard | | | | Mary Swann | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| yes | | | | W.W. 1 | | 218-10-3907R | | Lucille Howard 3405 Fairview Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | | 2 days | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | 2 yrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 19 65 to Dec. 19 65, that (I) (we) last saw the deceased alive on 29 Dec. 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Joshua R. Mitchell III | | | | 31 Dec. 65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Joshua R. Mitchell III M.D. | | | | 2202 Garrison Blvd. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | Jan. 3, 1965 | | Balto. National Cem. | | Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JAN 3 1966 | | R. E. F. F. F. | | H. Williams Funeral Home | | 319 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13435 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 65 13435 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Rosy Tona, Kosianna or Kasijano | | | 2. DATE AND HOUR OF DEATH Dec 31 @ 4:50 PM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY HOS | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hosp | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 208 S. Patterson Park Avn. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 3-6-93 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? 1st Papers |
| 13. FATHER'S NAME Alexander Chuppa | | | 14. MOTHER'S MAIDEN NAME Olga Montskowski | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Helen Kotowski 8102 Edwill Ave Balto 6 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Probable Acute Myocardial Infarction | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH Days |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) ASCD - Congestive Heart Failure | | years |
| | | | (C) Diabetes mellitus | | 1 year |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 7 AM Dec 30 1965 to 4 AM 12/31 1965 , that (I) (we) lost saw the deceased alive on 12/31 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John A. Mulholland M.D. | | | | 23B. DATE SIGNED 12/31/65 | |
| 23C. PHYSICIAN'S NAME (Type) John A. Mulholland M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE Jan 3 1966 | | 24C. NAME of CEMETERY or CREMATORY Holy Trinity Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Elkridge Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR DIPPEL BROS INC 1800 E LOMBARD ST | |



65 13436

BALTIMORE CITY HEALTH DEPARTMENT

65 13436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Howard E. WINTER

2. DATE AND HOUR PRONOUNCED DEAD

December 27, 1965 6:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3214 Presstman Street
Baltimore, Maryland 212164. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3214 Presstman Street 21216

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

June 10, 1889

9. AGE (in years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Printing

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jonas Winter

14. MOTHER'S MAIDEN NAME

Ida Bowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
No None16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr. Howard L. Winter

ADDRESS
3010 Wallace Circle
Huntington, W. Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Wenner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-28-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/31/1965

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Fickner & Sons 2801 N. Ave. Baltimore, Md. 117

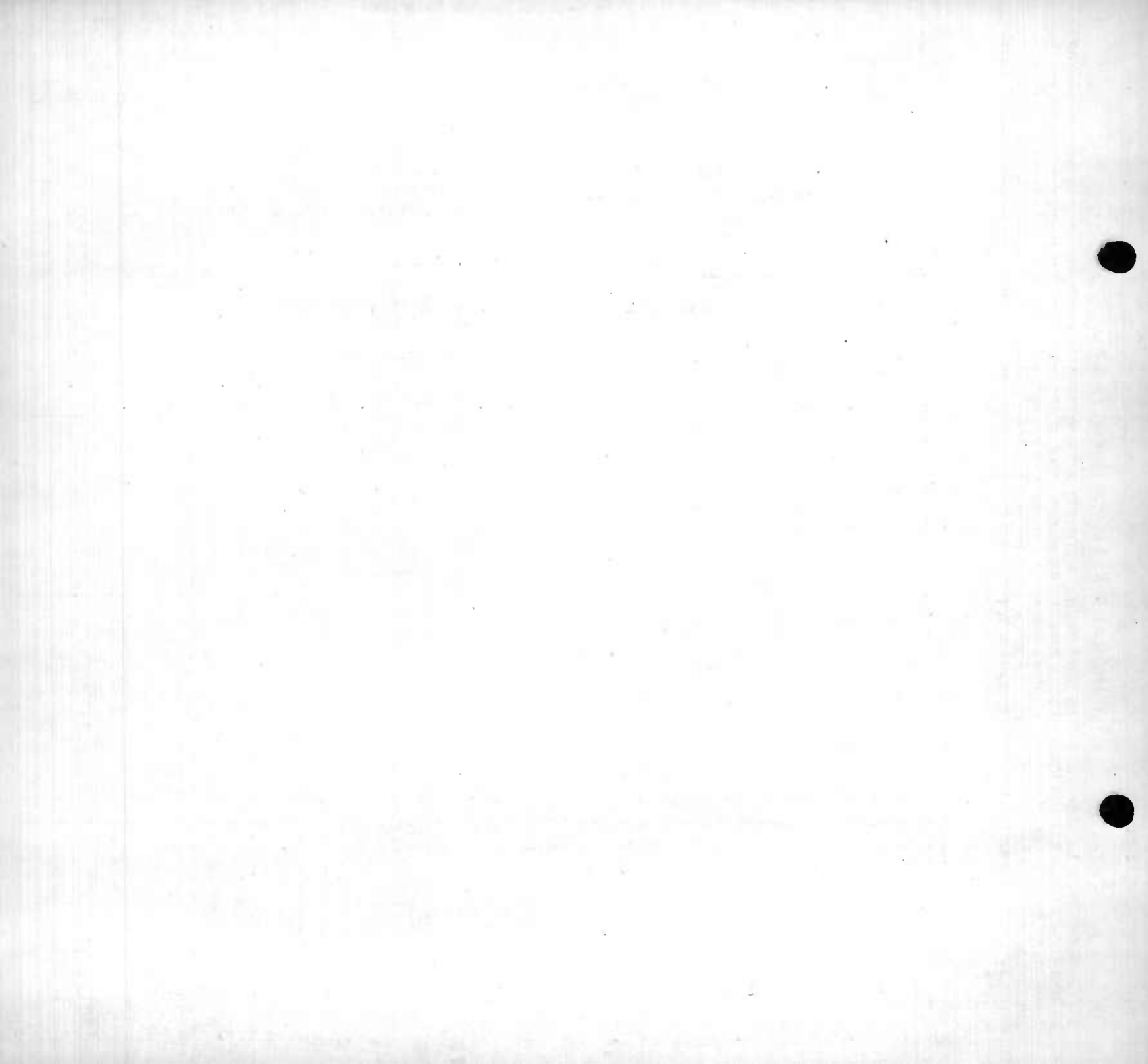
VALLEY FORD

22-10-1960

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

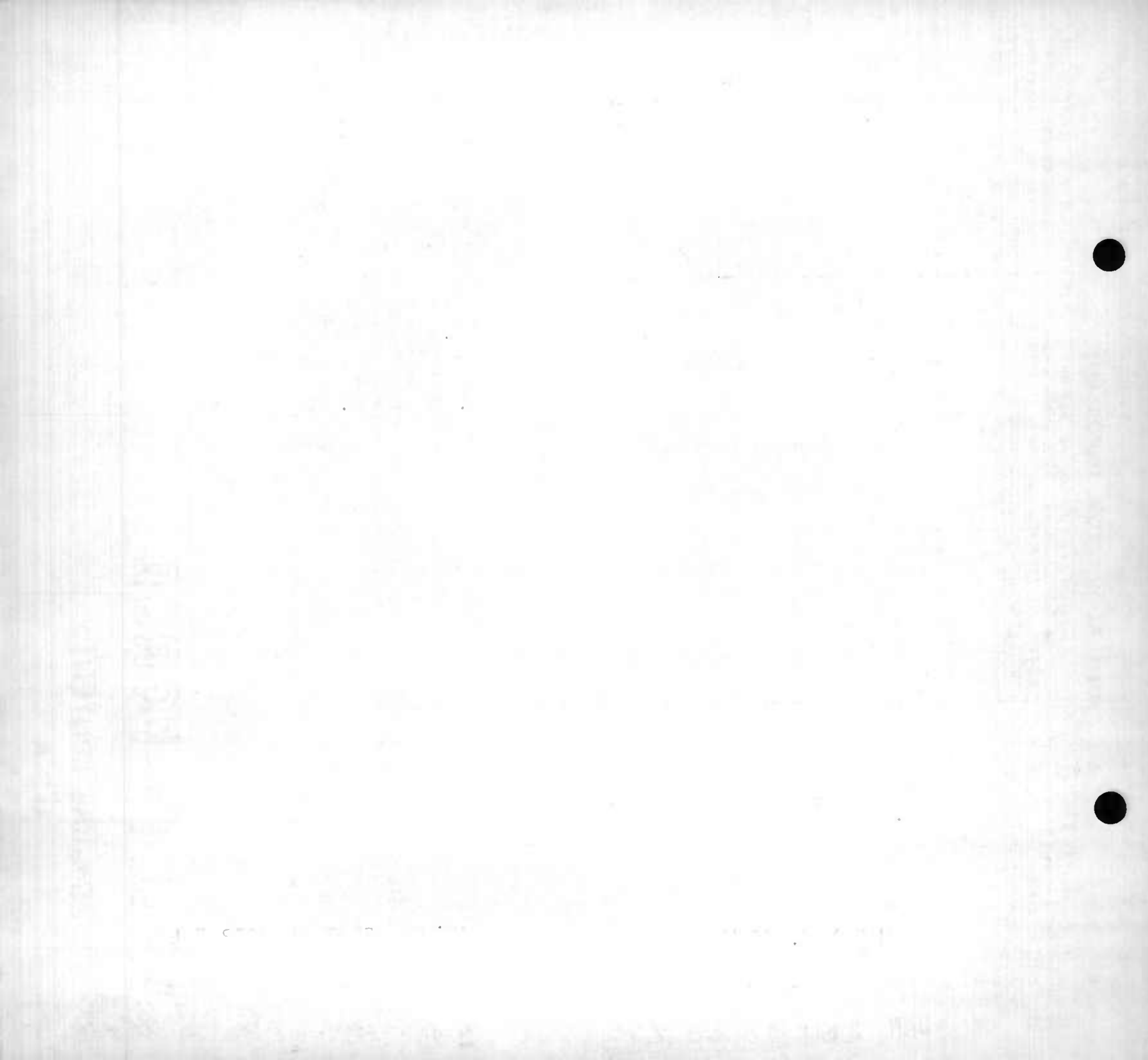
| | | | | | |
|---|------------------|--|-----------------------------------|--|--|
| BIRTH NO. 65 13437 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13437 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) C. Markland Kelly | | 2. DATE AND HOUR OF DEATH December 29, 1965 5:00 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1202 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3211 North Charles Street Baltimore, Maryland 21218 | | D. STREET ADDRESS (If rural, give location) 3211 North Charles Street 18 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Jan. 14, 1893 | 9. AGE (In years last birthday) 72 | 10. Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Car Dealer | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Calab Kelly | | 14. MOTHER'S MAIDEN NAME Mary Elizabeth | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS 19 E. Lexington St. Mr. Herbert E. Witz Baltimore, Md. 2 | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Rheumatic and Arteriosclerotic Heart Disease DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH Several years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, lactory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 19 65 to December 19 65, that (I) (we) last saw the deceased alive on December 23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Loy M. Zimmerman | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Dec 30, 65 | |
| 23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman | | M.D. 23D. ADDRESS 3202 Harford Rd. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 12/31/1965 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 24F. NAME OF REGISTRAR Robert E. Fairbank | |
| 24G. FUNERAL DIRECTOR Wm. J. Jickman & Sons | | 24H. ADDRESS Baltimore, Md. 17 | | 24I. NORTH & PA. Aves. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

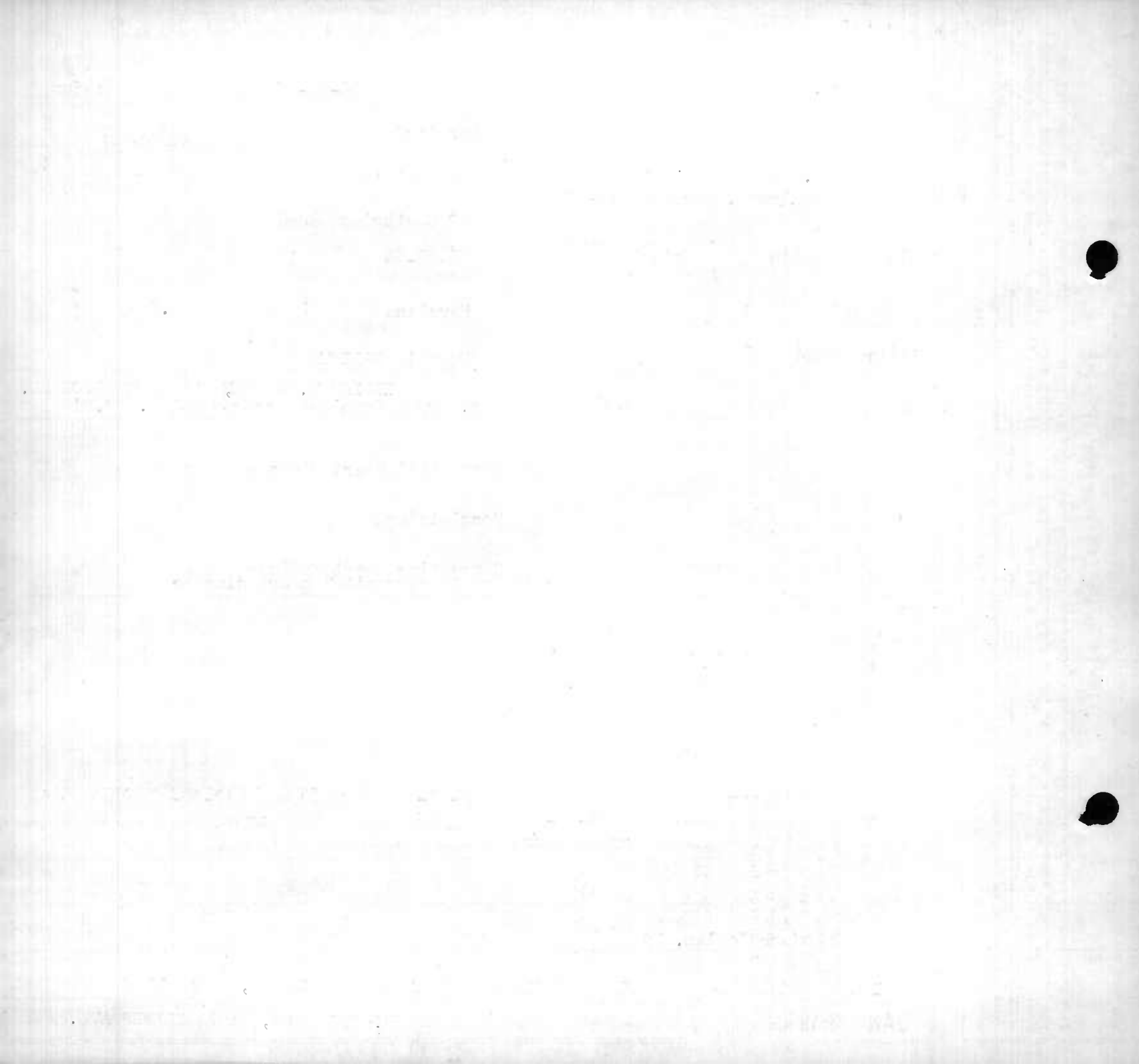
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|--|
| 65 13438 | | 65 13438 | | 65 13438 | |
| <div>CERTIFICATE OF DEATH</div> | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | Marian Beall Klarner | | 12/30/65 11:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| Union Memorial Hospital <small>(If not in hospital or institution, give street address or location)</small> | | Maryland <small>(If outside city limits, write RURAL and give township)</small> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | C. CITY OR TOWN | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 903 Woodson Road Apt. E | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | White | Married | 7/02/05 | 60 yrs | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Eugene E. Beall | | Bessie Robey | | U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| N/A | | | | Mr. William H. Klarner same address | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Coronary Artery Disease | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | N/A | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (A) (this hospital) attended the deceased from 12/18/65 to 12/30/65, that (B) (we) last saw the deceased alive on 11:55 AM 12/30/65 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| HARRY J. BROWN | | | | 12/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| HARRY J. BROWN | | UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 1/3/1966 | | Druid Ridge Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Pikesville, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 3 1966 | | Robert E. Taylor | | Wm. J. Dickner & Sons | |
| VS 150-REV. 1/1/65 | | | | Baltimore, Md. 17 North Pa. Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

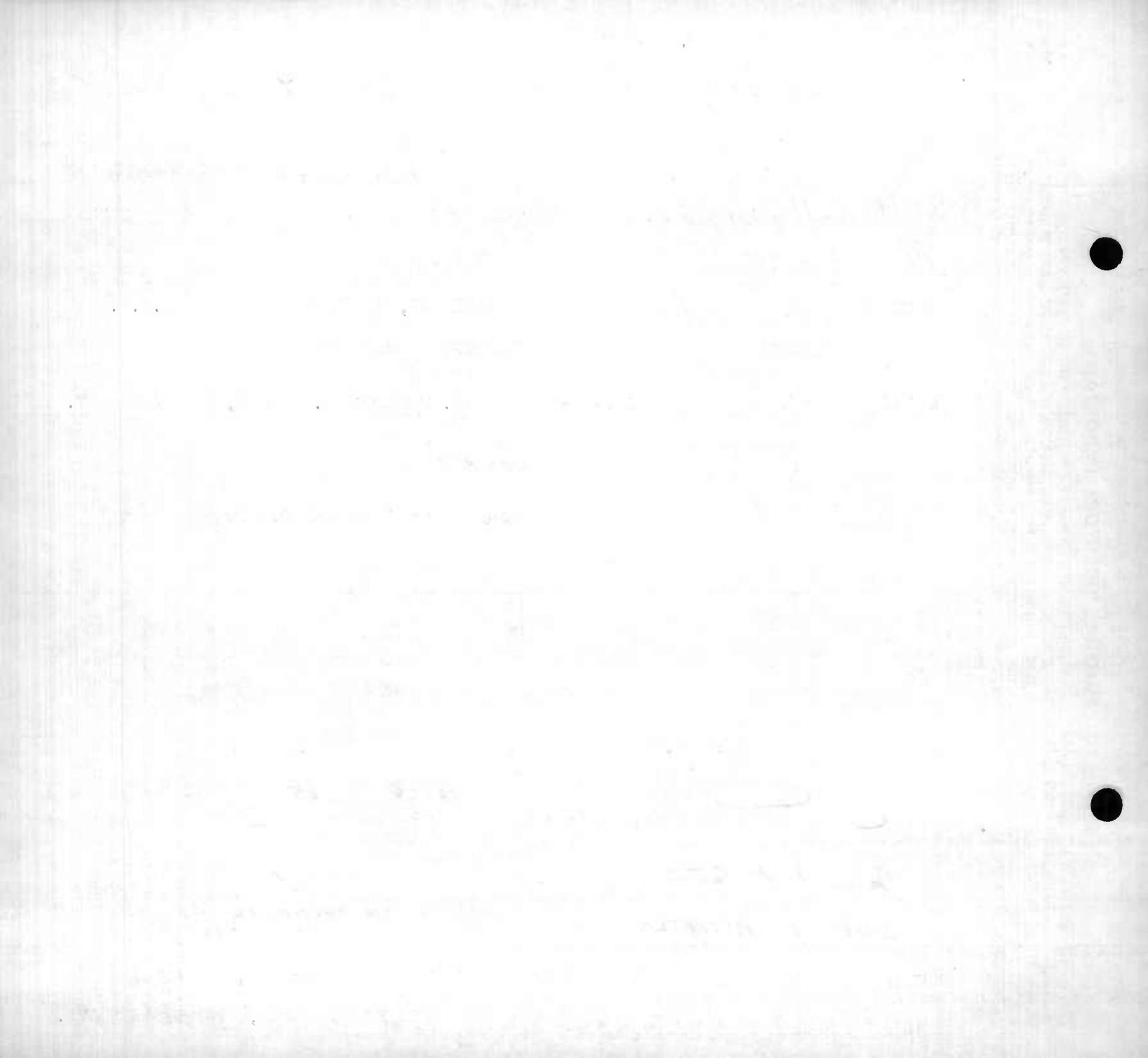
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|---|-------------------------|---|---|--|---|
| BIRTH NO. 64-17302-65 13439 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13439 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Clark, Susan M | | | 2. DATE AND HOUR OF DEATH 12-28-65 8:45pm M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital Baltimore, Maryland 21229 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville D. STREET ADDRESS (If rural, give location) 802 Southridge Road 21228 | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH 6-23-64 | 9. AGE (In years last birthday) 1 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baby | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME William Clark | | | 14. MOTHER'S MAIDEN NAME Cecelia KALISTA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS WILLIAM M. CLARK 802 SOUTHRIDGE RD. St. Agnes Hospital Records Balto. 29, Md | |
| 18. 754.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Con Congenital heart disease DUE TO (B) Monglloidism DUE TO (C) Congestive heart failure secondary to congenital heart disease | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (The doctor) attended the deceased from 6-23-19 64 to 12-28-19 65 , that (I) (me) last saw the deceased alive on 12-28-19 65 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (me) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Theodore Toulan, Md | | | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Theodore Toulan, Md | | 715 West Hill Play Balto Md 21225 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | 12/31/65 | BALTIMORE NATIONAL CEMETERY | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29 | |



FUNERAL DIRECTOR: IMPORTANT

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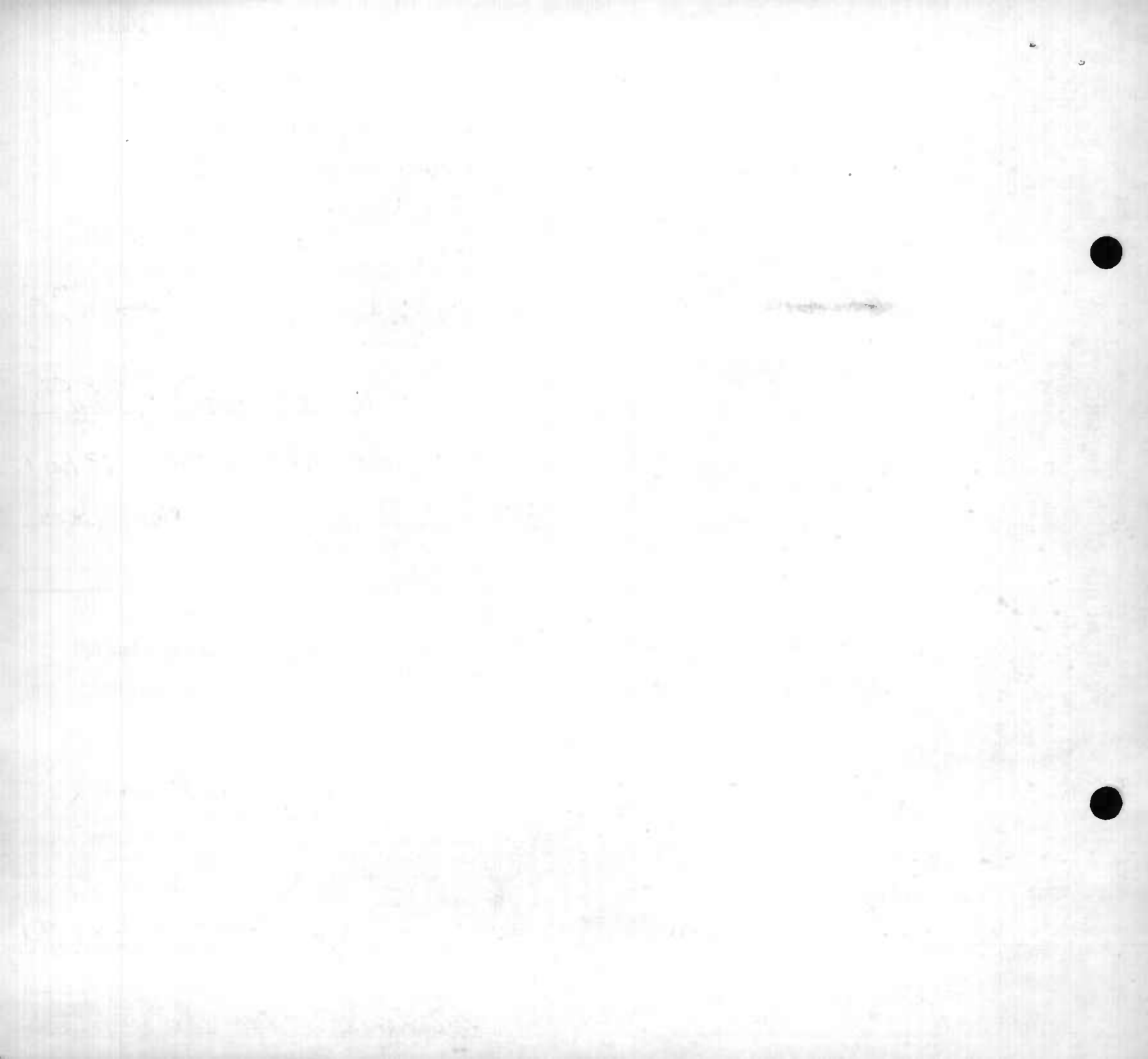
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|--|-------------------------|--|---|--|--|
| BIRTH NO. 65 13440 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13440 | |
| M.E. CASE NO. | | HENRY BERT. NELSON | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Bertram Nelson.</i> | | 2. DATE AND HOUR OF DEATH <i>12-28-65 2:45 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>21-02</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore # XXXXXXXXX 21223</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>1306 James St. 21223</i> | | | |
| 5. SEX <i>M.</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>MAY 30, 1881</i> | 9. AGE (In years last birthday) <i>84</i> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i> | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>UNKNOWN</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO YES W W I</i> | | | |
| 16. SOCIAL SECURITY NO. <i>215-03-0446A</i> | | 17. INFORMANT ADDRESS <i>MRS. FLORENCE M. NELSON, 1306 JAMES ST. 21223</i> | | | |
| 18. <i>442X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>UREMIA</i> DUE TO (B) <i>CARDIOVASCULAR RENAL DISEASE</i> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/28</i> 19 <i>65</i> to <i>12/29</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/29</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>James F. McCarter</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/29/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>JAMES F. MCCARTER</i> | | 23D. ADDRESS <i>SOUTH BALTIMORE GENERAL HOSPITAL 1213 LIGHT STREET</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12/31/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE NATIONAL CEMETERY</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

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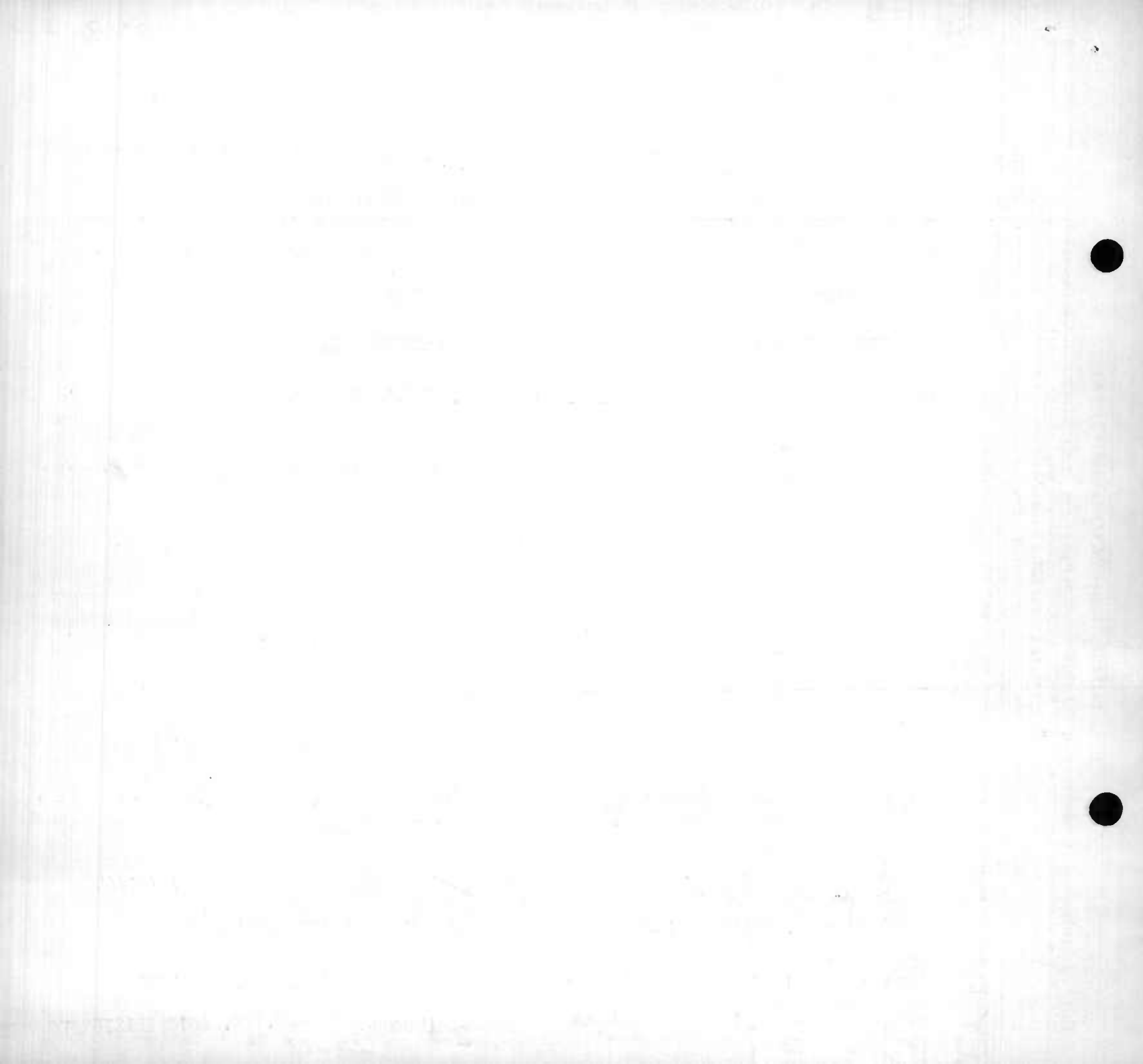
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|--|------------------|--|--------------------------|---|--|
| BIRTH NO. 65 13441 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13441 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Cohen, Myer | | 2. DATE AND HOUR OF DEATH 12-29-65 11 ¹⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #8 Balto | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP OF BALTO. | | D. STREET ADDRESS (If rural, give location) 511 Nassau ST | | 53-00 | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1887 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCER | | 10B. KIND OF BUSINESS OR INDUSTRY RETAIL | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Cohen, Phillip | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NO | | 17. INFORMANT Harry M. WALLEN 5356 Carriage Ct, Balto 29, Md | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I ACUTE MYOCARDIAL INFARCTION 18 hours | | CAUSE OF DEATH (A) DUE TO ASCVD | | INTERVAL BETWEEN ONSET AND DEATH Many years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none | | | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-29-65 to 12-29-65 that (I) (we) last saw the deceased alive on 12-29-65 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry M. Wallen | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-29-65 | |
| 23C. PHYSICIAN'S NAME (Type) Harry M. WALLEN | | 23D. ADDRESS 5356 Carriage Court Balto 29, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew | |
| 24D. LOCATION Baltimore, Maryland | | 24E. NAME OF REGISTRAR Robert E. Taylor | | 24F. FUNERAL DIRECTOR Sol. L. L. L. & Sons Inc 6010 Reisterstown Rd | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |



FUNERAL DIRECTOR: IMPORTANT

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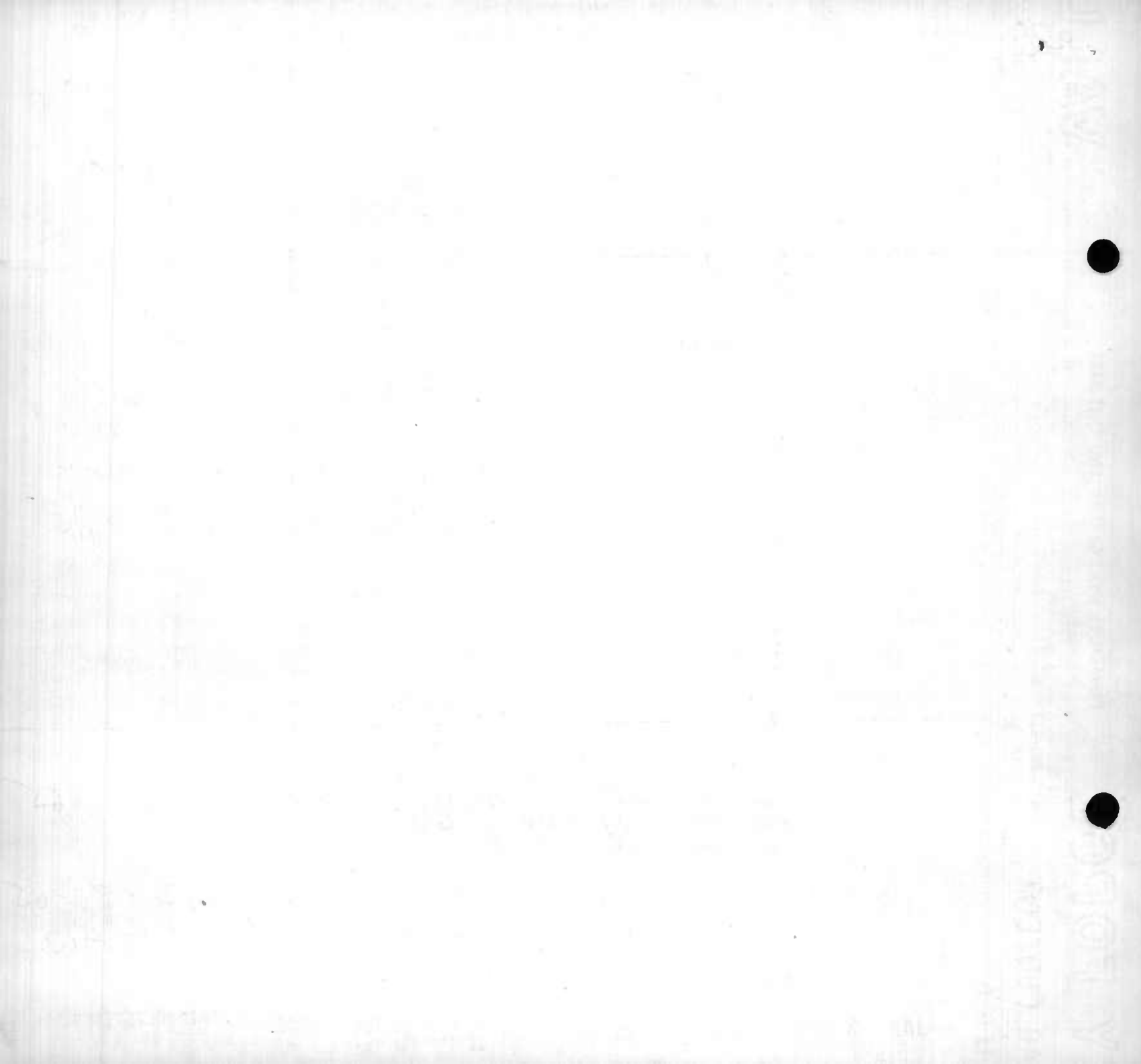
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13442 | | CERTIFICATE OF DEATH | | Registered No. 65 13442 | |
|---|---|--|--|---|---|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) LOUIS CRANE | | | | 2. DATE AND HOUR OF DEATH DECEMBER 30, 1965 1 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE NURSING HOME HOUSE IN THE PINES | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5811 KEY AVENUE | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) 81 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT | | | 10B. KIND OF BUSINESS OR INDUSTRY RETAIL | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME CHARLES CRANE | | | | 14. MOTHER'S MAIDEN NAME FRED A BERTHA ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 215-09-2918 | | 17. INFORMANT ADDRESS MRS. FRED A EMMER 5811 KEY AVENUE | | | | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slofing the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH (A) Thrombosis, Central Vessel DUE TO (B) _____ DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | Arteriosclerosis, generalized | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 19 60 to Dec 30 19 65 , that (I) (we) last saw the deceased alive on Dec 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Sylvan D Goldberg | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/31/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. SYLVAN GOLDBERG | | | | 23D. ADDRESS 420 MEDICAL ARTS BUILDING | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/31/65 | | 24C. NAME of CEMETERY or CREMATORY OHEL YAKOV | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Falkner | | 25C. FUNERAL DIRECTOR SAL LEVINSON | | ADDRESS BROS. INC. 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13443 | |
|--|-------------------------|--|---------------------------------|---|---|
| BIRTH NO. 65 13443 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ROSE SMITH | | 2. DATE AND HOUR OF DEATH DECEMBER 30, 1965 10:30 AM. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION FRIEDLERS NURSING HOME 2449 SHIRLEY AVENUE | | A. STATE MARYLAND B. COUNTY Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 3406 CROYDON ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED (specify) | 8. DATE OF BIRTH 1885 | 9. AGE (In years lost birthday) 80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME STECKEL | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. MEYER CHERNOCK ADDRESS 6318 WINNER AVENUE | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. General arteriosclerosis | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1948 to Dec 1965 , that (I) (we) last saw the deceased alive on 11-16-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Irvin Sauber | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Irvin Sauber | | 23D. ADDRESS 6905 Park Heights Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/31/65 | | 24C. NAME of CEMETERY or CREMATORY HEBREW MT. CARMEL | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Salyer | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. ADDRESS 6010 REISTERSTOWN RD | | | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Abraham
ROY DUNCAN

2. DATE AND HOUR PRONOUNCED DEAD

December 28, 1965 9:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Victoria Hotel Room 20

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Victoria Hotel 704 E Balto. St. Rm. 20

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

May 1, 1900

9. AGE (in years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Cutter10B. KIND OF BUSINESS OR INDUSTRY
Garment Factory

11. BIRTHPLACE (State or foreign country)

Radford, Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Levy Duncan

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
No16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Roy Abraham Duncan Jr.

Martinsville, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cirrhosis of the liver
DUE TO Acute and chronic alcoholism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

Dec. 30, 1965

23C. NAME of CEMETERY or CREMATORY

Rose Lawn Burial Park

23D. LOCATION

(City, town, or county)

Martinsville,

(State)

Virginia

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

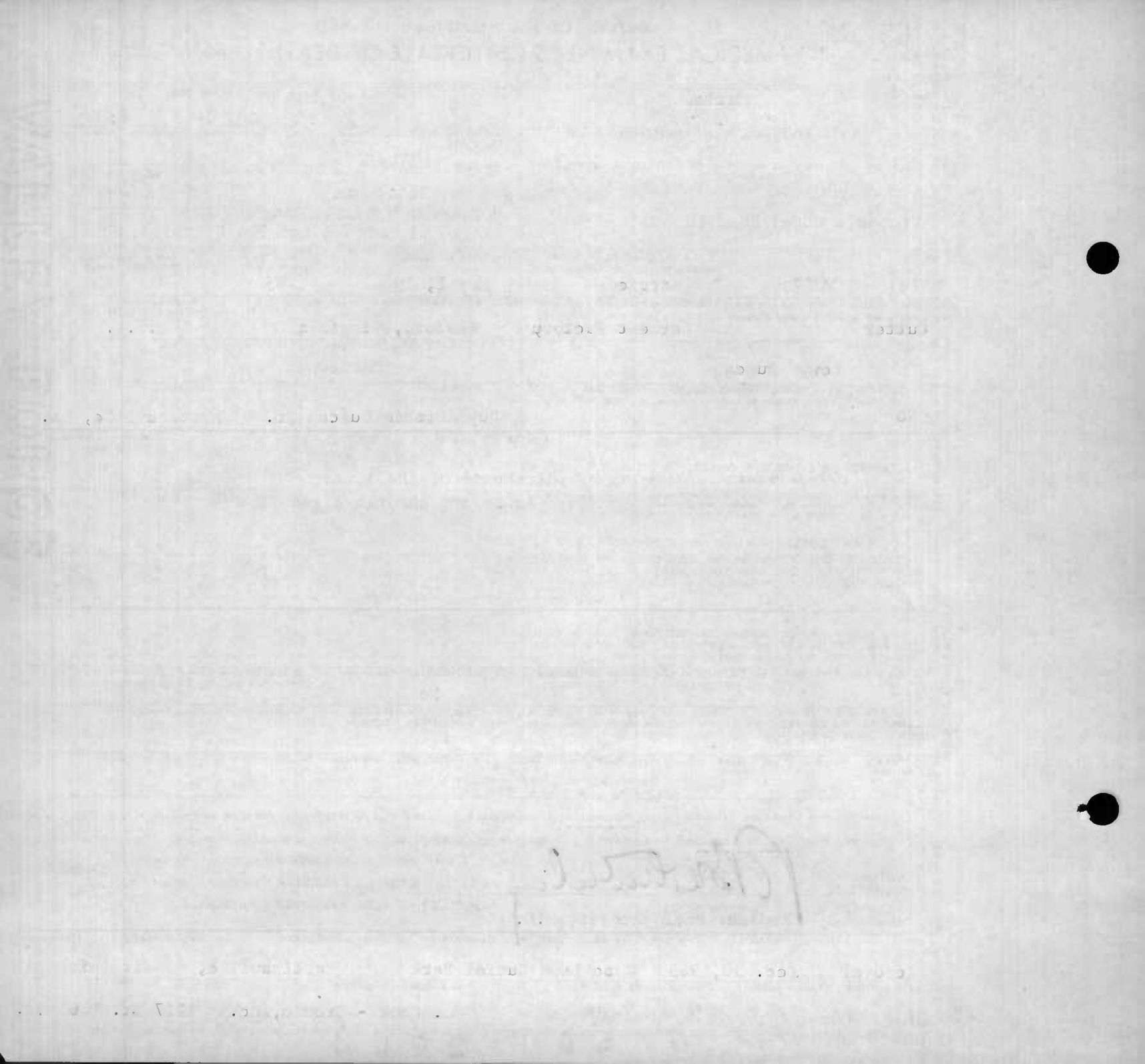
24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

Wm. Cook - Brooks, Inc. 1217 St. Paul St.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|--|--|---|
| BIRTH NO. 65 13445 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13445 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Anna Mary Wolf | | | 2. DATE AND HOUR OF DEATH 12-29-65 12:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 14-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 17 D. STREET ADDRESS (If rural, give location) 1906 Mt. Royal Ave | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 5-19-28 | 9. AGE (In years last birthday) 37 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Kentucky | |
| 13. FATHER'S NAME ? (Unknown) | | 14. MOTHER'S MAIDEN NAME ? (Unknown) | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 30-07-5525 | | 17. INFORMANT Hospital chart | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute M.I. ASCVD on approval of Med. Examiner | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-21-65 to 11-26-65, that (I) (we) last saw the deceased alive on 11-26-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Henderson | | | | 23B. DATE SIGNED 12-29-65 | |
| 23C. PHYSICIAN'S NAME (Type) M.D. | | | | 23D. ADDRESS Linden Avenue & Madison St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Howard County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Gass | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc Baltimore, Md. 21202 | | | |

1902
2-11-27
Kew Gardens
11/27

Boyle's
W
name

Hospital
Cante 11-1
A 800

on approval of Med. Examiners

02

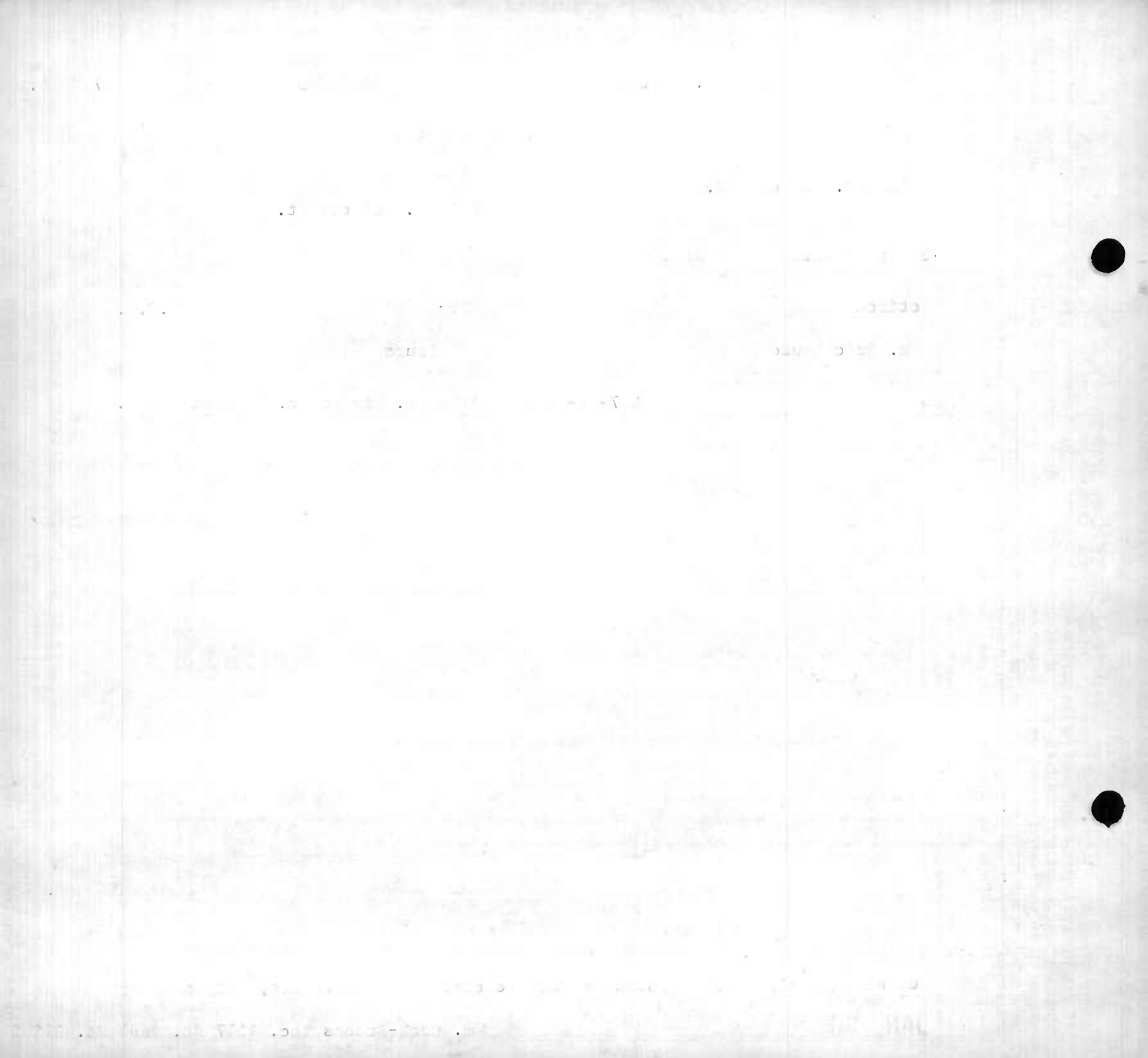
11/27
11/27
11/27

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13446 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13446 | |
|--|--|--|--|---|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Johanna C. Burton | | 12/30/65 7:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | Maryland | | 12-03 | |
| 2828 N. Calvert St. | | | | Baltimore | | D. STREET ADDRESS (If rural, give location) | |
| 2828 N. Calvert St. | | | | Baltimore | | 2828 N. Calvert St. | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Female | | White | | Widowed | | 9/19/1882 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired | | | | Virginia | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Wm. Brickhouse | | | | Laura ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | 217-01-9118 | | Allan H. Fisher Jr. MdNatlBnkBg. | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Cerebral Hemorrhage DUE TO | | 1 month | |
| | | | | (B) Hypertensive Cardiovascular Disease DUE TO | | Over a year. | |
| | | | | (C) ✓ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ✓ | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| D NONE | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 4, 1965 to Dec. 30, 1965, that (I) (we) lost saw the deceased alive on Dec. 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | |
| Frank N. Ogden | | | | | | Dec. 30, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| FRANK N. OGDEN | | | | 2701 N. Calvert St Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/31/65 | | Lorraine Park Cemetery | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| JAN 3 1966 | | Robert E. Fisher | | Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202 | | | |



BIRTH NO. 65 13447 LaPlata, Md. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13447

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM J. CROWLEY, JR.

2. DATE AND HOUR PRONOUNCED DEAD

December 29, 1965 1:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Waldorf

D. STREET ADDRESS (If rural, give location)

Box C2 Idlewood Manor

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Baby

8. DATE OF BIRTH

11/4/65

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

1 21

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Laplata, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. J. Crowley Sr.

14. MOTHER'S MAIDEN NAME

Joyce Happle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown, (If yes, give war or dates of service))16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Wm. J. Crowley Sr. Lot C2 Idlewood Manor

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/31/65

23C. NAME of CEMETERY or CREMATORY

Glen Haven Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202

VALLEY HOF

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13448 | |
|--|------------------|--|---------------------------------------|---|--|
| BIRTH NO. 65 13448 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FREDERICK L. REYNOLDS | | 2. DATE AND HOUR OF DEATH 12-30-65 1 540 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY | | A. STATE MARYLAND B. COUNTY 4-02 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 516 W. FAYETTE ST | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Unknown | 8. DATE OF BIRTH MARCH 3-18-85 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing | | 11. BIRTHPLACE (State or foreign country) Unknown | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Rufus Reynolds | | | |
| 14. MOTHER'S MAIDEN NAME Maggie Floyd | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown none | | | |
| 16. SOCIAL SECURITY NO. 213-09-7075 | | 17. INFORMANT Mrs. Ruth Z. Frizzell ADDRESS 1605 Tredegar Av Catonsville, Md. | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO Myocardial Infarction | | 11 Days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHOPNEUMONIA | | | | 7 Days | |
| 19A. DATE OF OPERATION 12-19-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory Distress | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) No | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> No | | 21F. HOW DID INJURY OCCUR? No | |
| 22. I certify that (I)-(this hospital) attended the deceased from 12-19-65 to 12-30-65 and that (I)-(we) last saw the deceased alive on 12-30-65 and that in (my)-(our) opinion death occurred on the date and hour and from the causes stated above. (I)-(We) (did) (did-not) view the body after death. | | | | | |
| 23A. SIGNATURE Henry A. Sabontz M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) Henry A. Sabontz | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec 31, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemt. | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. LOCATION (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Sterling Funeral Estate ADDRESS 736 Edmondson Ave., Catonsville | |

1955 40 100
100

Continuing

Present

Wayside

Apple Road

515-5-07571 March 2, 1955

None

April 2, 1955 March 2, 1955

March 2, 1955

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GERTRUDE EDWARDS FOXWELL

2. DATE AND HOUR PRONOUNCED DEAD

December 29, 1965 4:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

B. COUNTY ST. MARY'S

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Leonardtwn

D. STREET ADDRESS (If rural, give location)

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

Oct. 13, 1894

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SCHOOL TEACHER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

JAMES RICHARD EDWARDS

14. MOTHER'S MAIDEN NAME

ELIZABETH EDWINA YATES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-46-8289

17. INFORMANT

ADDRESS

STEPHEN T. FOXWELL LEONARDTOWN, MARYLAND

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive Pulmonary Embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Fracture of Right Femur.
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Therapy Room

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Seton Institute

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 26 '65 A.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Knocked to floor during argument.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/30/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

JAN. 3, 1966

23C. NAME of CEMETERY or CREMATORY

ST. ALOYSIUS CEMETERY

23D. LOCATION

(City, town, or county)

(State)

LEONARDTOWN, ST. MARY'S, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

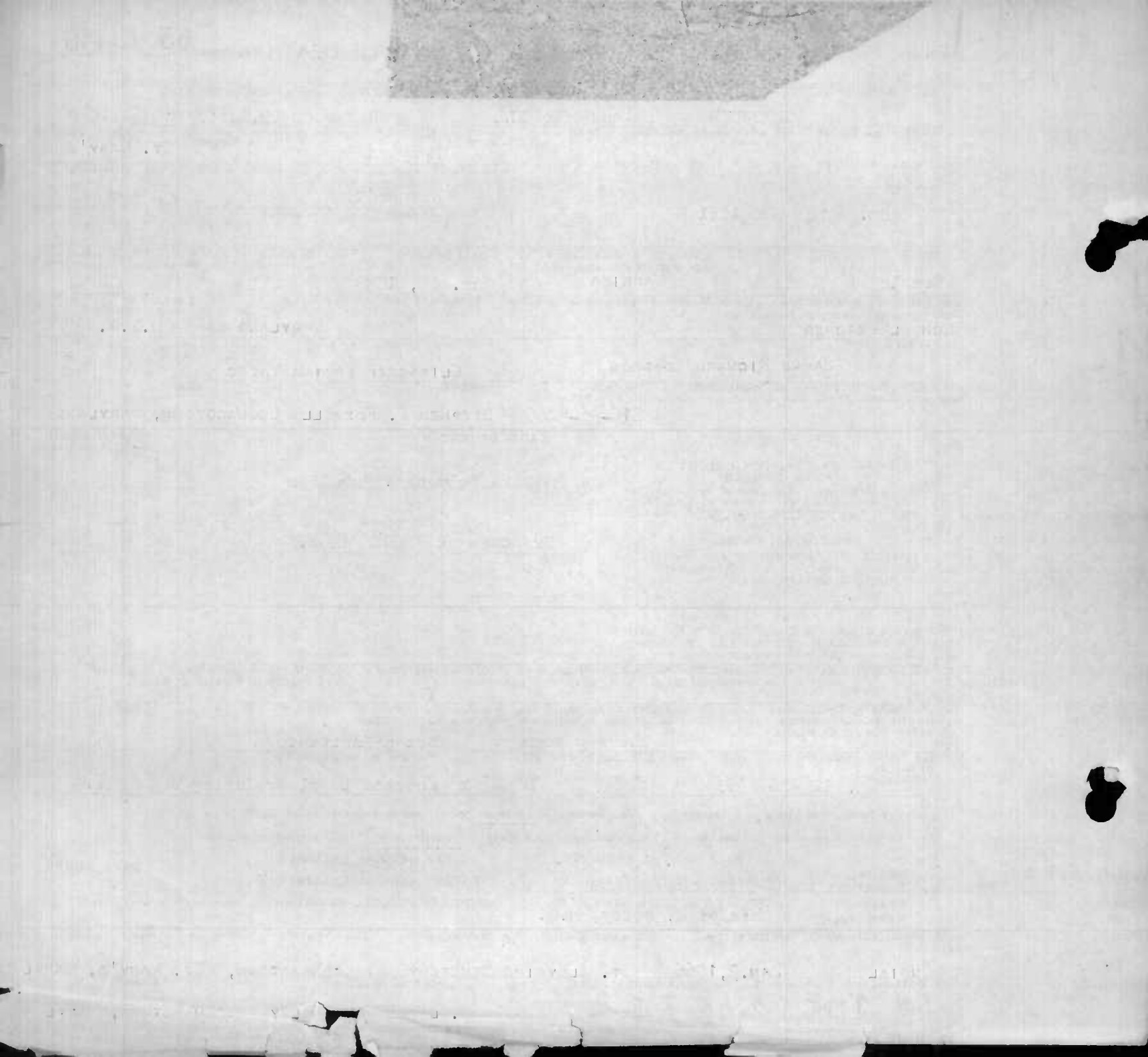
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

W. CLARKE MANGLEY

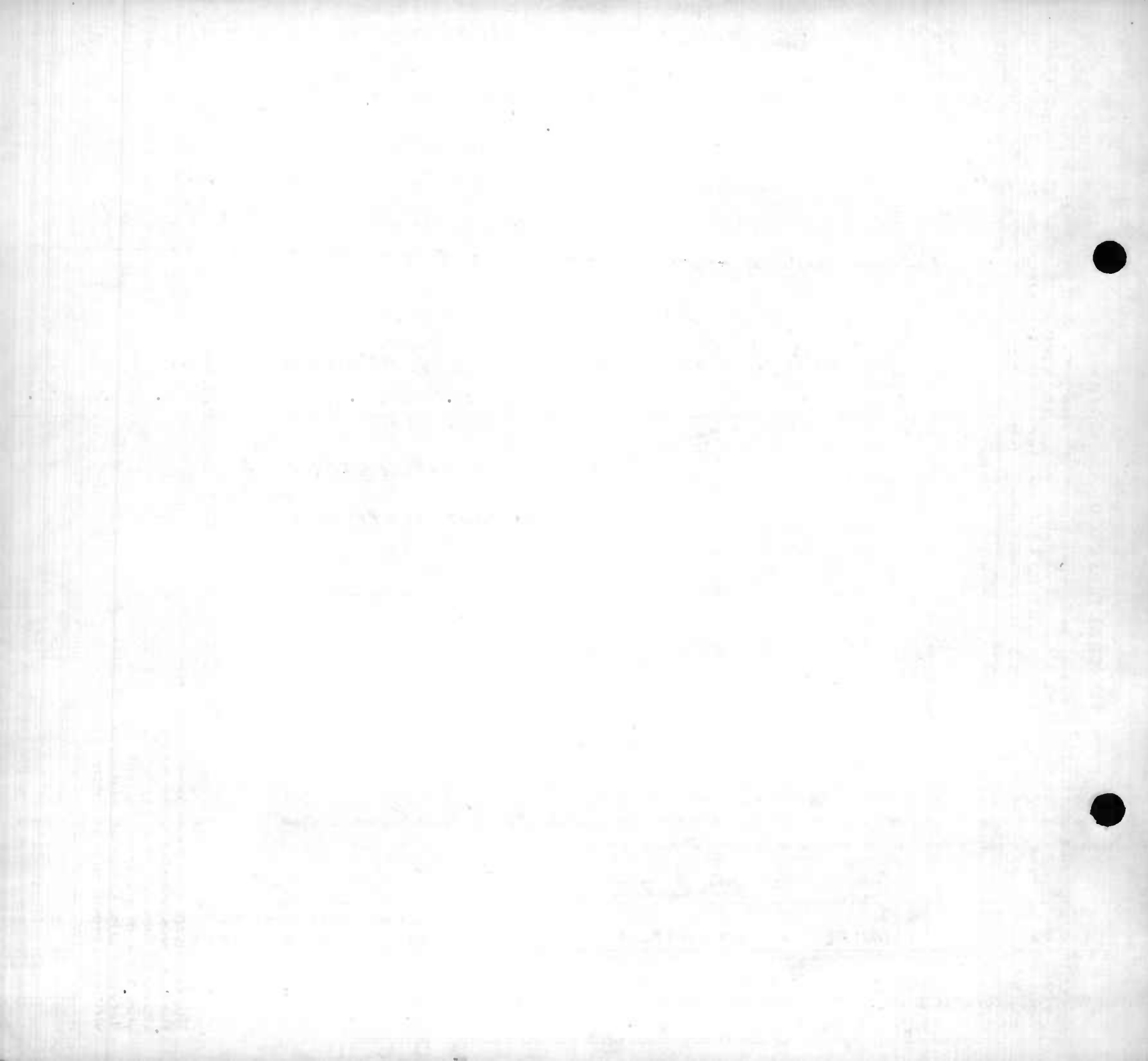
LEONARDTOWN, MARYLAND



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13450 | |
|---|------------------|--|----------------------------|---|--|
| BIRTH NO. 65 13450 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Edward C. Colmus | | 2. DATE AND HOUR OF DEATH 12-30-65 7:50 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 23-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp | | D. STREET ADDRESS (If rural, give location) 1731 So. Charles St. | | | |
| 5. SEX M. | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-2-03 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Frank J. Colmus | | 14. MOTHER'S MAIDEN NAME Theresa Sabbat | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Grace B. Colmus 1731 S. Charles St. | |
| 18. 200.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) GENERALIZED METASTASIS DUE TO (B) MALIGNANT LYMPHOMA CELL PROBABLY (C) | | INTERVAL BETWEEN ONSET AND DEATH 5 months 6 months - 1 yr. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 12-17 19 65 to 12-30 19 65, that (we) last saw the deceased alive on 12-30 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James F. McCarter | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES F. MCCARTER | | 23D. ADDRESS SOUTH BALTIMORE GENERAL HOSP. 1213 LIGHT STREET | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 11 86 | | 24C. NAME of CEMETERY or CREMATORY Meadowridge | |
| 24D. LOCATION (City, town, or county) (State) Dorsey, Howard Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. F... | |
| 25C. FUNERAL DIRECTOR Mc Cully | | 25D. ADDRESS 130 E. Fort Ave | | | |



65 13451

BALTIMORE CITY HEALTH DEPARTMENT

65 13451

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALBERT FLEISCHER Sr.

2. DATE AND HOUR PRONOUNCED DEAD

December 30, 1965

7:18P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7907 Oakwood Road

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10/28/1907

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sheet metal mechanic - Heating & air conditioning

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Fleischer

14. MOTHER'S MAIDEN NAME

Isabella Weiss

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-10-9277

17. INFORMANT

Mrs Margaret Fleischer

ADDRESS

above

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-30-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/4/66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

John F. Cowan & Son Inc. Hollins

ADDRESS

901 St.
23, Md.

WALLACE & GORDON

W. Wallace & Gordon

Refused from medical examiner 21 Jan
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13452 | |
|--|---------------------|---|--|---|---|
| BIRTH NO. 65 13452 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARY ROBINSON | | 2. DATE AND HOUR OF DEATH DEC. 26, 1965 6:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQ. HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 18-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 23 D. STREET ADDRESS (If rural, give location) 217 N. CARROLLTON AVE. | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) — | 8. DATE OF BIRTH JUNE 24, 1886 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Orange Co. Ver. | |
| 13. FATHER'S NAME Robert's Townes | | 14. MOTHER'S MAIDEN NAME Martha. ? | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Jesse Robinson 3318 N. 18th St. Phila. Pa. | |
| 18. E936.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CERTIFICATION APPROVED BY <i>[Signature]</i> CHIEF OF ASS. MEDICAL EXAMINER | | CAUSE OF DEATH EMBOLISM OF PULMONARY FR. FRACTURE OF HIP with infarction of middle lower lobes, Right lung. INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 217 N. Carrollton Ave. 18-02 | |
| 21D. TIME OF INJURY (Approx.) 12 21-25 65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fallen lying on floor | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC. 25 19 65 to DEC. 26 19 65 , that (I) (we) last saw the deceased alive on DEC. 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED DEC. 26/65 | |
| 23C. PHYSICIAN'S NAME (Type) S. B. LUAGUE | | 23D. ADDRESS M.D. FRANKLIN SQ HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/31/65 | | 24C. NAME OF CEMETERY or CREMATORY W.H. Calvary Cem. | |
| 24D. LOCATION (City, town or county) (State) Cedar Hill Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR Williams Funeral Home | | 25D. ADDRESS 319 N. Schomaker St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|---------------------------------|---|---|
| BIRTH NO. 65 13453 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13453 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CHARLES A. SMITH | | 2. DATE AND HOUR OF DEATH Dec. 30, 1965 12 45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224 | | A. STATE MARYLAND B. COUNTY 26-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4940 EASTERN AVENUE | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 1876 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY Building | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Alfred E. Smith | | 14. MOTHER'S MAIDEN NAME Bertha Bell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Osteomyelitis @ Femur ~ 2 yrs | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-16 1962 to Dec. 30 1965 , that (I) (we) last saw the deceased alive on Dec. 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Barry Wayne Uhr M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED Dec. 30, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) BARRY WAYNE UHR M.D. | | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 11/1/66 | | 24C. NAME OF CEMETERY or CREMATORY Louisa Park Cemetery Baltimore, Maryland | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Andrew J. Sulphur Sp. Rd. | | | |

11/24/1905

11/24/1905

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|---|---|---|
| BIRTH NO. 65 13454 | | CERTIFICATE OF DEATH | | Registered No. 65 13454 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JENNIE M. BARRETT | | | 2. DATE AND HOUR OF DEATH Dec. 29, 1965 3 4 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 710 Gorsuch Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 710 Gorsuch Ave. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH Sept. 16, 1867 | 9. AGE (In years last birthday) 98 | II Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Principal | | 10B. KIND OF BUSINESS OR INDUSTRY Education | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME James W. Barrett | | | 14. MOTHER'S MAIDEN NAME Isabelle McDonnell | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Miss Winefred Barrett | | ADDRESS 710 Gorsuch Ave. Baltimore, Maryland |
| 18. 422.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury at complication which caused death.) Myocarditis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1940 to 12-29 1965 , that (I) (we) last saw the deceased alive on 28-12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wm. Cook-Brooks | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-30-65 |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-31-1965 | 24C. NAME of CEMETERY or CREMATORY St. Johns Cemetery | | 24D. LOCATION (City, town, or county) (State) Old York Rd. & Greenmount Ave. Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Farkner | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks ADDRESS Towson 1050 York Rd. Towson, Maryland | |

301.22.0

Isabelle No name
Also Winifred name

| BIRTH NO. 65 13455 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 13455 | |
|--|------------------|---|---------------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) KENNETH EPPERS | | 2. DATE AND HOUR PRONOUNCED DEAD December 29, 1965 3:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3614 Parkdale Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3614 Parkdale Ave. | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Oct 1, 1941 | 9. AGE (in years last birthday) 24 | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plate Maker | | 10B. KIND OF BUSINESS OR INDUSTRY Maran Printing Co Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Wayne O. Eppers, Sr | | 14. MOTHER'S MAIDEN NAME Alice I. Kane | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) no no ? | |
| 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Rita A. Eppers. 3614 Parkdale Ave | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (A) Massive internal hemorrhage DUE TO gunshot wound of the chest (B) DUE TO (C) | | | |
| 19A. DATE OF OPERATION 12-29-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3614 Parkdale Ave. | |
| 21D. TIME OF INJURY (APPROX.) 12-29-65 1:00 A | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Shot self in chest | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12-29-65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 1/3/66 | | 23C. NAME of CEMETERY or CREMATORY Poplar Grove | |
| 24A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 24B. NAME OF REGISTRAR Robert E. Taylor | | 24C. FUNERAL DIRECTOR Austin E. Donovan-3818 Roland Ave | |
| 24D. LOCATION (City, town, or county) (State) Balto Co, Md | | ADDRESS | | | |

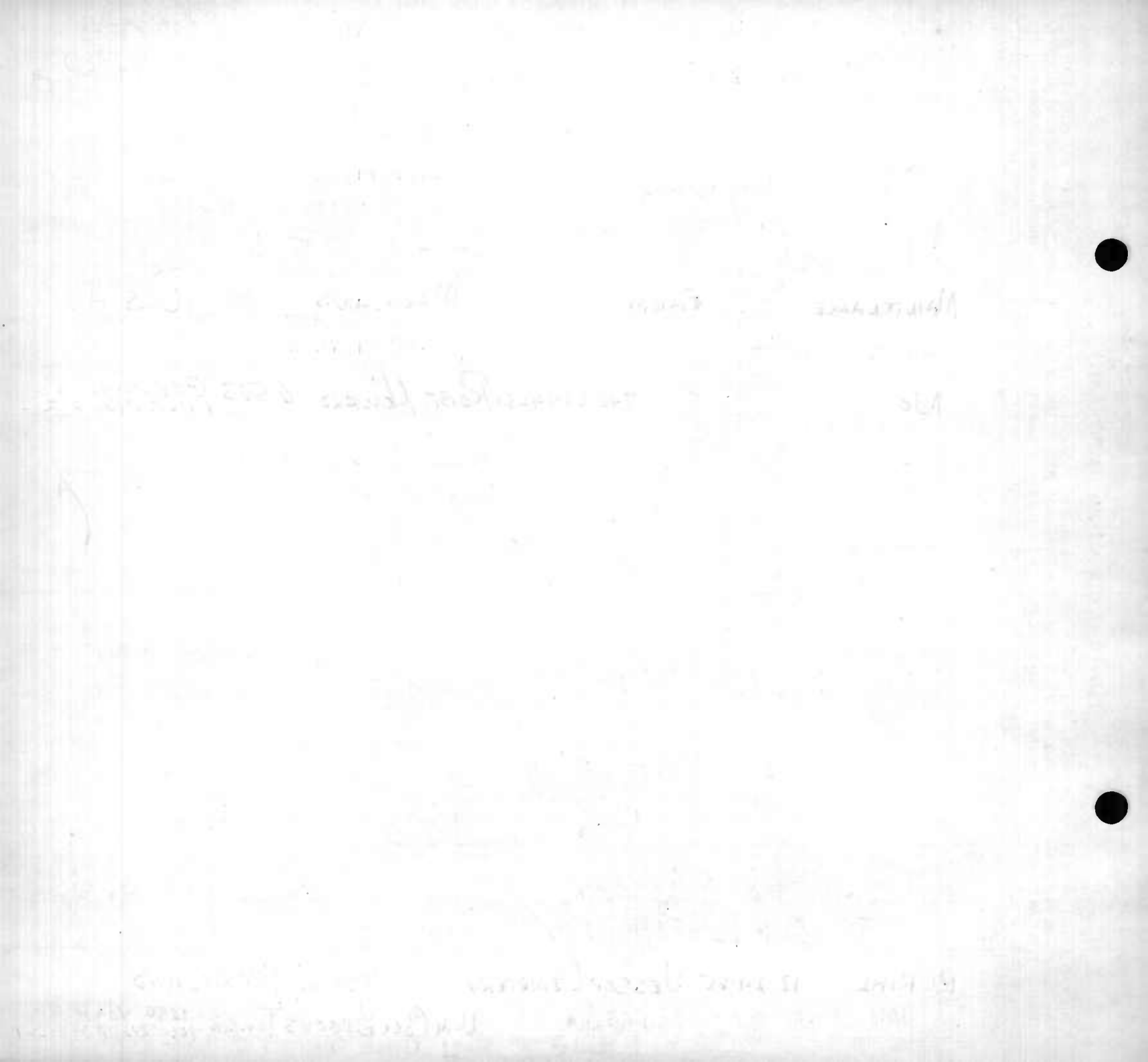
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|---------------------|---|------------------------------------|---|---|
| BIRTH NO. 65 13456 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13456 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Charles Howard</i> | | 2. DATE AND HOUR OF DEATH <i>12-21-65 4:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Balto</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>COCKEYSVILLE 5300</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>Box 107 WESTERN RUN ROAD</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i> | 8. DATE OF BIRTH <i>3-26-12</i> | 9. AGE (In years, months, days) <i>53</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MAINTENANCE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>FARM</i> | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>CHARLES HOWARD</i> | | 14. MOTHER'S MAIDEN NAME <i>LOUISE LIETNER</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>740-62-1403</i> | | 17. INFORMANT <i>ROBT. HOWARD 6503 CRESTWOOD RD BALT. MD. 21212</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>413 X I</i> | | CAUSE OF DEATH (A) <i>rheumatic heart disease and</i> (B) <i>renal failure</i> (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>12-15</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>rheumatic valvulitis</i> | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-21-65</i> to <i>12-21-65</i> and that (I) (we) lost saw the deceased alive on <i>12-21-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Edward Tarlov</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-21-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>EDWARD TARLOV</i> | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>12-24-65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>JESSOP CEMETERY</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>SPARKS, MARYLAND</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fajana</i> | | 25C. FUNERAL DIRECTOR <i>WM COOK BROOKS TOWSON</i> | |
| ADDRESS <i>1650 YORK RD TOWSON, MD 21204</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 13457

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

65 13457
LEWIS F. HENRY

2. DATE AND HOUR OF DEATH

DEC. 22, 1965 11:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

Balti

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

LUTHERVILLE

6300

D. STREET ADDRESS (If rural, give location)

629 W. SEMINARY AVE.

5. SEX

M

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

FEB. 17, 1902

9. AGE (In years last birthday)

63

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LIVEMAN

10B. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

ELIZABETH UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes, U.S. Army 1919 to Aug 16, 1922

16. SOCIAL SECURITY NO.

UNK.

17. INFORMANT

MRS. MARY R. HENRY - SAME

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

MYOCARDIAL INFARCTION

INTERVAL BETWEEN ONSET AND DEATH

1 DAY

(B) DUE TO

ARTERIOSCLEROSIS

15 YEARS

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from DEC. 22 19 65 to DEC. 22 19 65, that (we) last saw the deceased alive on DEC. 22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE

L. Evan Custer, M.D.

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

DEC. 23, 1965

23C. PHYSICIAN'S NAME (Type)

L. EVAN CUSTER

M.D.

23D. ADDRESS

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-27-65

24C. NAME of CEMETERY or CREMATORY

Jessop Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore Co. Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

25B. NAME OF REGISTRAR

Robert E. Fink

25C. FUNERAL DIRECTOR

Wm. Cook Brooks Tawson 1050 York Rd Towson 4 Md

11-7-11 11:11 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13458 | |
|--|----------------------|--|--|--|--|
| BIRTH NO. 65 13458 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Jasuah Earnest Gorsuch | | Dec. 17, 1965 9:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Ardleigh Nursing Home 2099 Rockrose Ave Baltimore, Md. | | A. STATE B. COUNTY Md. Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glencoe, Md. 21070 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | | |
| 5. SEX M. | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Aug. 19, 1876 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Business Cards | | 11. BIRTHPLACE (State or foreign country) Glencoe, Md. | |
| 13. FATHER'S NAME Thomas Talbot Gorsuch | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 342 18 9420 | | 17. INFORMANT ADDRESS Edith Gorsuch, Glencoe, Md. 21070 | |
| 18. 4221 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Arteriosclerotic Cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH 15 Years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 8, 1965 to Dec. 17, 1965 , that (I) (we) last saw the deceased alive on Dec. 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Lloyd E. Saylor</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12, 20, 65 | |
| 23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M.D. | | 23D. ADDRESS 3902 Greenmount Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12, 20, 65 | | 24C. NAME OF CEMETERY or CREMATORY Gorsuch | |
| | | | | 24D. LOCATION (City, town, or county) (State) Glencoe, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR <i>Robert E. Fagan</i> | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks TOWSON | |
| | | | | ADDRESS Towson, Md. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13459 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | Registered No. 65 13459 | | | |
|--|--|-------------------|--|--|--|---|--|--|--|-------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) <i>Brown, George sheldon</i> | | | | <i>Dec-24-1965</i> | | | | <i>13. 45 P. M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | A. STATE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | <i>Unknown Memorial Hospital</i> | | | | <i>Maryland</i> | | | |
| <i>Baltimore, Maryland</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | <i>Baltimore</i> | | | |
| D. STREET ADDRESS (If rural, give location) | | | | <i>53-00</i> | | | | <i>2638 Matthews Drive, Baltimore</i> | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | If Under 1 Yr. Months Days | |
| <i>Male</i> | | <i>Caucasian</i> | | <i>Married</i> | | <i>5/22/12</i> | | <i>53</i> | | <i>13. 45 P. M.</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| <i>Manager</i> | | | | <i>Weber moving + storage</i> | | | | <i>Maryland</i> | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>U.S.A.</i> | | | | <i>Brown George F.</i> | | | | <i>Mary Bunting</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| <i>Unknown</i> | | | | <i>577-10-1258</i> | | | | <i>Unknown</i> | | | |
| 18. <i>152.0 I</i> | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) <i>Carcinoma of III-portion of duodenum and</i> | | | | (B) <i>Carcinomatosis</i> | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO | | | | DUE TO | | | |
| ANTECEDENT CAUSES | | | | DUE TO | | | | DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | (C) | | | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | |
| <i>No at present admission</i> | | | | <i>No</i> | | | | <i>No</i> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| <i>No</i> | | | | <i>No</i> | | | | <i>No</i> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| <i>1</i> | | | | <i>While At Work</i> | | | | <i>While At Work</i> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>Dec-19-65</i> 19 to <i>Dec-24</i> 19 <i>65</i> . | | | | that (we) last saw the deceased alive on <i>Dec-24</i> 19 <i>65</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. <i>(We)</i> (did not) view the body after death. | | | | 23A. SIGNATURE | | | |
| <i>Kang Fan</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | <i>Dec-24-65</i> | | | |
| <i>KANG FAN</i> | | | | <i>M.D.</i> | | | | <i>20069</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| <i>Burial</i> | | <i>12, 28, 65</i> | | <i>Dulaney Valley</i> | | <i>Towson, Md.</i> | | <i>JAN 3 1966</i> | | <i>Robert E. Taylor, M.D.</i> | |
| 25C. FUNERAL DIRECTOR ADDRESS | | | | 25D. FUNERAL DIRECTOR ADDRESS | | | | 25E. FUNERAL DIRECTOR ADDRESS | | | |
| <i>Wm. Cook-Brooks Towson, Towson, Md. 21204</i> | | | | <i>Wm. Cook-Brooks Towson, Towson, Md. 21204</i> | | | | <i>Wm. Cook-Brooks Towson, Towson, Md. 21204</i> | | | |

2/1/1972

Grand Canyon

Marj Grinting

Barbara Davis

10/1/1972

Barbara Davis

10/1/1972

Grand Canyon

Barbara Davis

10/1/1972

Grand Canyon

10/1/1972

Grand Canyon

10/1/1972

Barbara Davis

10/1/1972

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

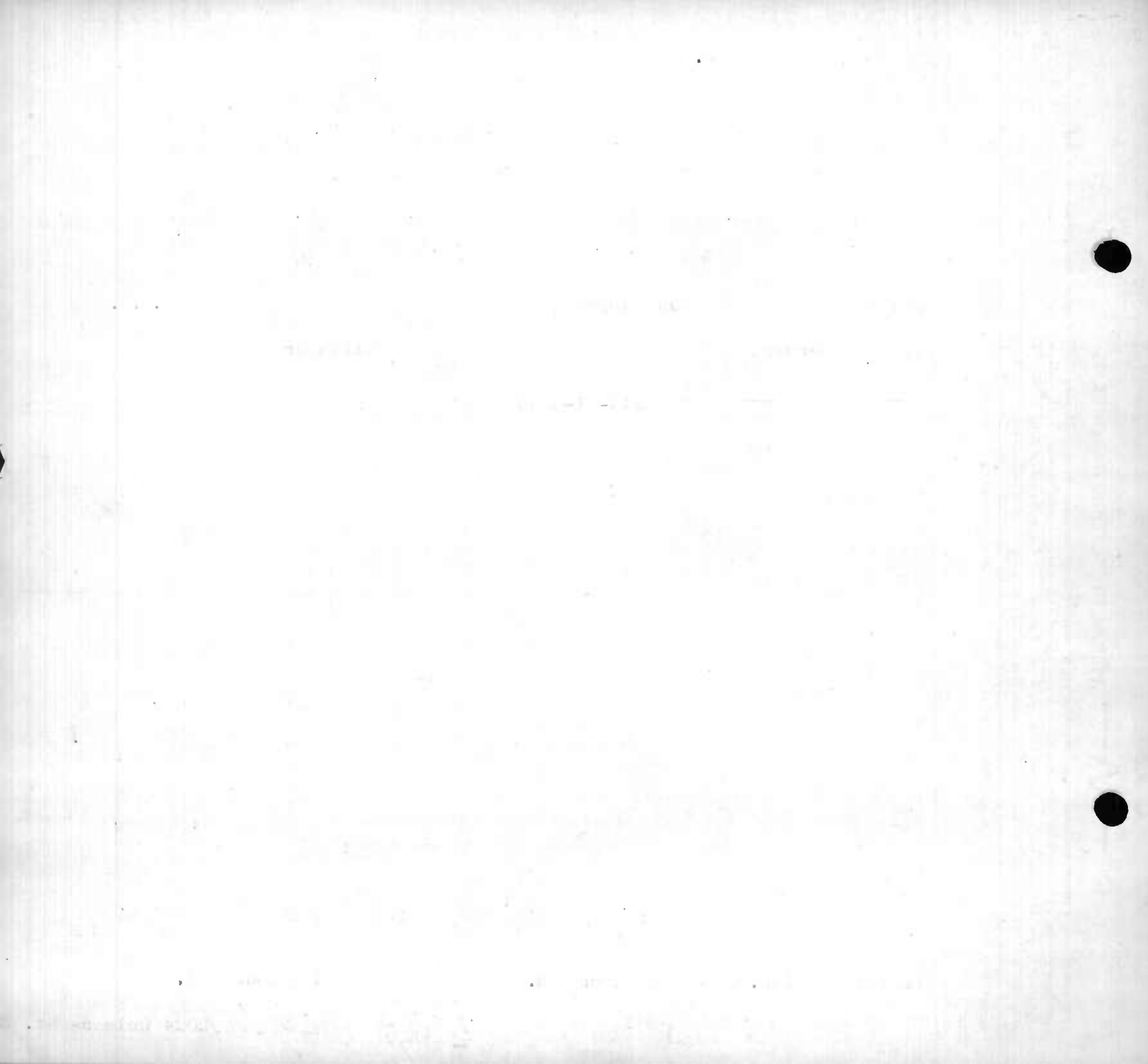
| BIRTH NO. 65 13460 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13460 | |
|--|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ARTHUR PATTON | | | | 2. DATE AND HOUR OF DEATH Dec. 27, 1965 | | 2:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL 4940 EASTERN AVENUE BALTIMORE, MARYLAND 24 | | | | A. STATE MARYLAND | | B. COUNTY BALTIMORE | |
| 5. SEX M | | | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY unemployed | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 13. FATHER'S NAME JAMES PATTON | | | | 14. MOTHER'S MAIDEN NAME MARY MASON | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | | | 16. SOCIAL SECURITY NO. unemployed | | 17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY CARCINOMA | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH ~ 1 yr. | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 27, 1965 to Dec. 27, 1965, and that (I) (we) last saw the deceased alive on Dec. 27, 1965 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Barry Wayne Uhr | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec. 27, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) BARRY WAYNE UHR | | | | 23D. ADDRESS 4940 EASTERN AVENUE #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 12-30-65 | | 24C. NAME OF CEMETERY or CREMATORY SCHAFER PLOT | |
| 24D. LOCATION WYTHEVILLE, VIRGINIA | | | | 24E. LOCATION (City, town, or county) WYTHEVILLE, VIRGINIA | | 24F. LOCATION (State) VIRGINIA | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR TOWSON 1050 YORK RD TOWSON, MARYLAND 21204 | |

37-61-11
JJ W-656

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|------------------|--|---|
| 65 13461 | | 65 13461 | | 65 13461 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| CHARLES WERNER | | Dec. 31, 1965 | | 455 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224 | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2025 CHRISTIAN ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| M | W | NEVER MARRIED | 7/9/08 | 57 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Printing | | Sun Papers | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| EARHART Werner | | CARRIE Mulfinger | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 214-01-5345 | | BCH RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 581.1 I | | (A) HEPATIC FAILURE | | 2 wks + | |
| ANTECEDENT CAUSES | | (B) LAENNEC'S CIRRHOSIS | | 3 yrs + | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| D | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 19 1965 to Dec. 31 1965, that (I) (we) last saw the deceased alive on Dec. 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| Barry Wayne Uhr | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | Dec. 31, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| BARRY WAYNE UHR | | 4940 EASTERN AVENUE #21224 BALTIMORE CITY HOSPITALS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | Jan. 4/66 | | Oak Lawn Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 3 1966 Robert E. Taylor | | Philip Herwig | | 2024 Orleans St. 3 | |



65 13462

BALTIMORE CITY HEALTH DEPARTMENT

65 13462

BIRTH NO. 65-20014

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

COLLIN MORRIS

2. DATE AND HOUR PRONOUNCED DEAD

December 28, 1965

4:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

310 S Parrish St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

AUG. 10, 1965

9. AGE (in years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

4

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

COLLING, MORRIS SR.

14. MOTHER'S MAIDEN NAME

SHARON DARLENE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

COLLING, MORRIS SR 310 S. PARRISH ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Waterhouse-Friderichsen Syndrome
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/30/65

23C. NAME of CEMETERY or CREMATORY

WOODLAWN

23D. LOCATION

(City, town, or county)

(State)

BALTO, MD.

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Paul E. Charney
3617 Chestnut Ave.

WATKINS FORGE

PAID CONTENT

42

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13463 | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. 65 13463 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) JAMES Joseph Phyles | | | 2. DATE AND HOUR OF DEATH 12-28-1965 12:15 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY U.S.A. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| (If not in hospital or institution, give street address or location) | | | D. STREET ADDRESS (If rural, give location) 1222 Light Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH 5/12/1923 | 9. AGE (In years last birthday) 42 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME HENRY H. PHYLES | | | 14. MOTHER'S MAIDEN NAME ALICE BAILEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 283-18-1008 | 17. INFORMANT Thomas E. Phyles | | ADDRESS 6808 WASH. BLVD. 21227 |
| 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) Congestive Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCUD | | | CAUSE OF DEATH ASCUD INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XX (this hospital) attended the deceased from 19 to 19 , that XX (we) last saw the deceased alive on 19 and that XX (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. M. Kaufman M.D. | | | 23B. DATE SIGNED 12-28-65 | | 23C. PHYSICIAN'S NAME (Type) Dr. M. Kaufman M.D. |
| 23D. ADDRESS 1213 Light Street Balto. Md. 21230 | | | 23E. FUNERAL DIRECTOR South Baltimore General Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-31-65 | | 24C. NAME OF CEMETERY or CREMATORY DALTON NAT. CEM | |
| 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR Rand E. Schowet | | 25D. ADDRESS 3615 Chestnut Ave | | | |

CERTIFICATE OF DEATH

Registered No. 65 13464

BIRTH NO. 65 13464

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John William Shelton

2. DATE AND HOUR OF DEATH
Fri-Dec-31-1965

5:36 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF (If not in hospital or institution, give street
address or location)SINAI HOSPITAL AMENDED
Sinai Hospital 1/6 19664. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 21215

D. STREET ADDRESS (If rural, give location)

5227 Reisterstown Road

5. SEX
Male6. RACE
White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married8. DATE OF BIRTH
Oct 13 19049. AGE (In years
last birthday) 61If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auto Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Used Car Business

11. BIRTHPLACE (State or foreign country)

TEXAS / Bristol, Tenn.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO. 220-
07-591117. INFORMANT Mrs Marjorie Shelton
(Wife) ADDRESS
Same18. 420.1 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-20-1959 to 12-15-1965.
that (I) (we) last saw the deceased alive on 12-31-1965 and that (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

1-3-66

23C. PHYSICIAN'S
NAME (Type)

Julius M. Waghelstein

M.D.

23D. ADDRESS

1010 St. Paul St. Baltimore Md. 21202

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Tues
Jan 4 1966

24C. NAME OF CEMETERY or CREMATORY

Lake View Cemetery, Carroll Co., Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

1400 S. Charles St. Baltimore, Md. 21230

CURTIS E. EVANS

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 13465

BIRTH NO. 65 13465

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHRISTINA A. MALATESTA

2. DATE AND HOUR OF DEATH

Dec. 29 1965

9.50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

408 S.High St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

408 S.High St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Oct. 18 1883

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John B. Cuneo

14. MOTHER'S MAIDEN NAME

Clara Retaliata

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Marie Malatesta 408 S.High St.

18. 55011 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, ostehenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Phyisic Valouler Heart Disease ?
Chronic Emphysema (Chronic)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (nally medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED
While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 28 1965 to Dec. 29 1965,
that (I) (we) last saw the deceased alive on Dec. 29 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

1/1/65

23C. PHYSICIAN'S
NAME (Type)

I. J. FREINGLOS

M.D.

23D. ADDRESS

2002 E. Pratt St

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan. 3rd/66 New Cathedral Cemetery

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

Baltimore Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

25B. NAME OF REGISTRAR

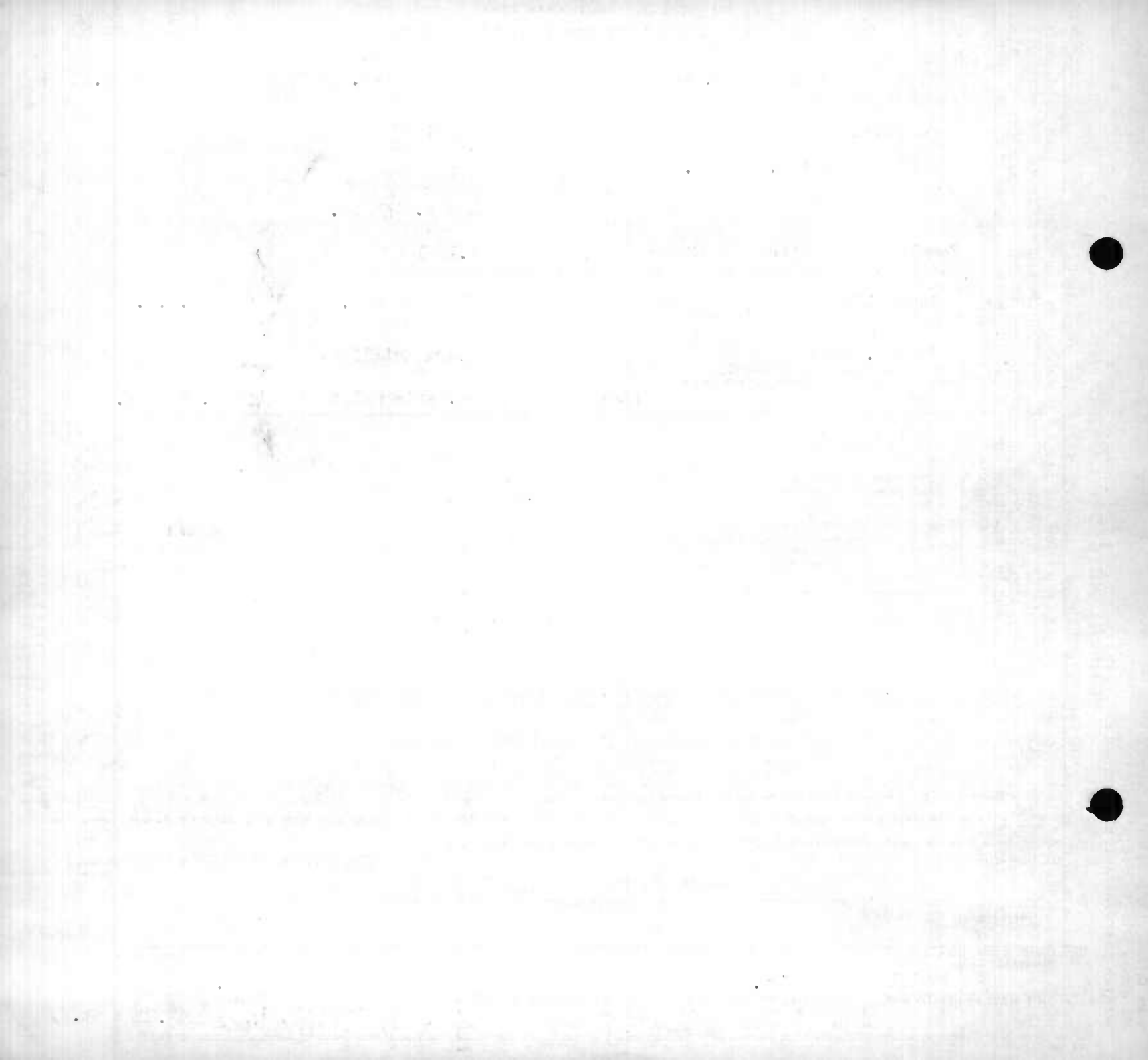
Robert E. Taylor

25C. FUNERAL DIRECTOR

Angela Della Noce

ADDRESS

322 S.High St.



D-416

65 13466

BALTIMORE CITY HEALTH DEPARTMENT

65 13466

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DelBrocco
ANGELO DEL BRACCO

2. DATE AND HOUR PRONOUNCED DEAD

December 31, 1965 9:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3211 E. Fairmount Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

April 15, 1892

9. AGE (In years last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

stoker (retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-05-4553

17. INFORMANT

ADDRESS

Vincent DelBrocco 3000 E. Fayette St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Severe bronchopneumonia**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-1-66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/4/66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

ADDRESS

WALTER POLICE

W. J. [Signature]

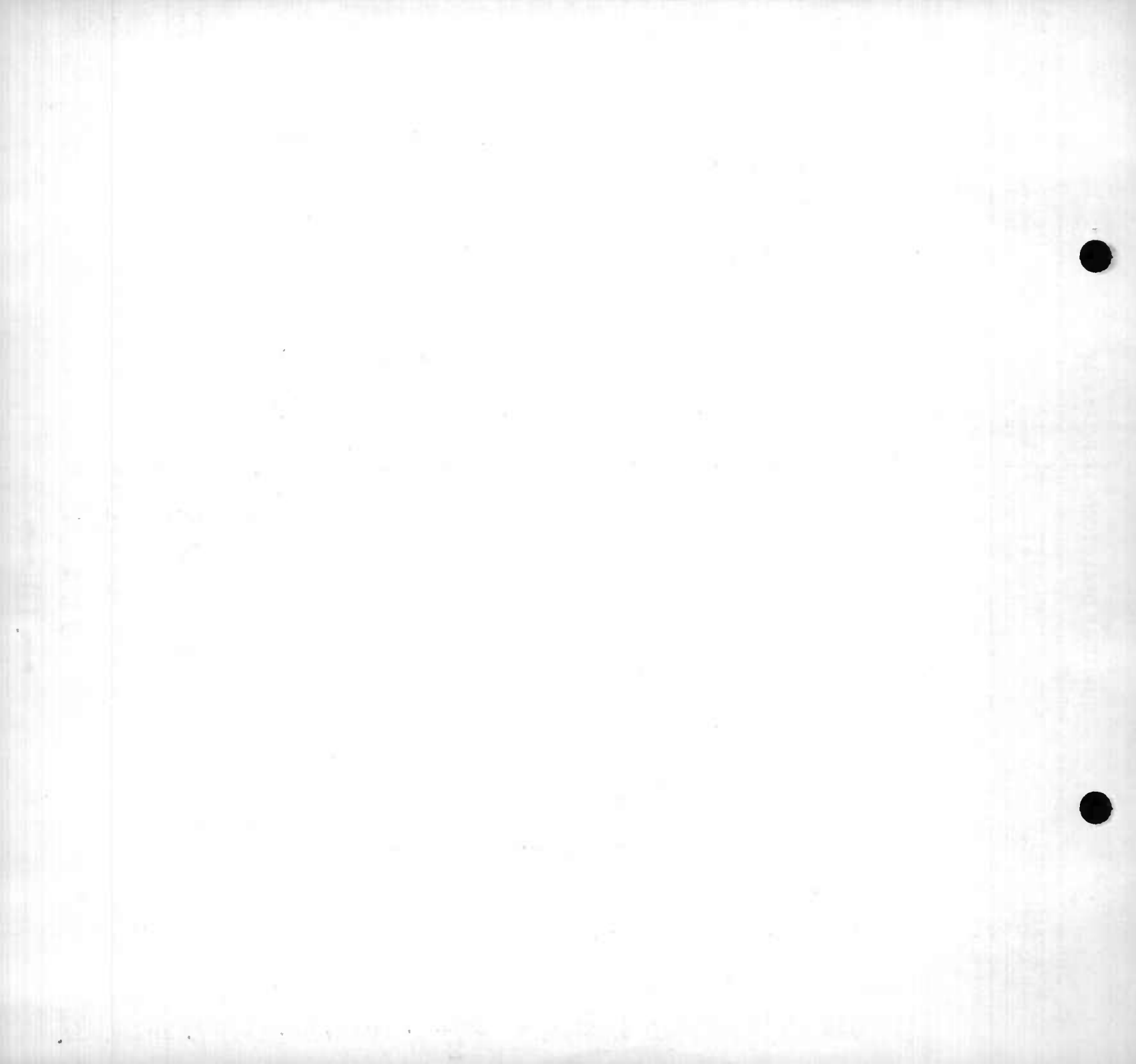
W. J. [Signature] [Signature] [Signature]

W. J. [Signature] [Signature] [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

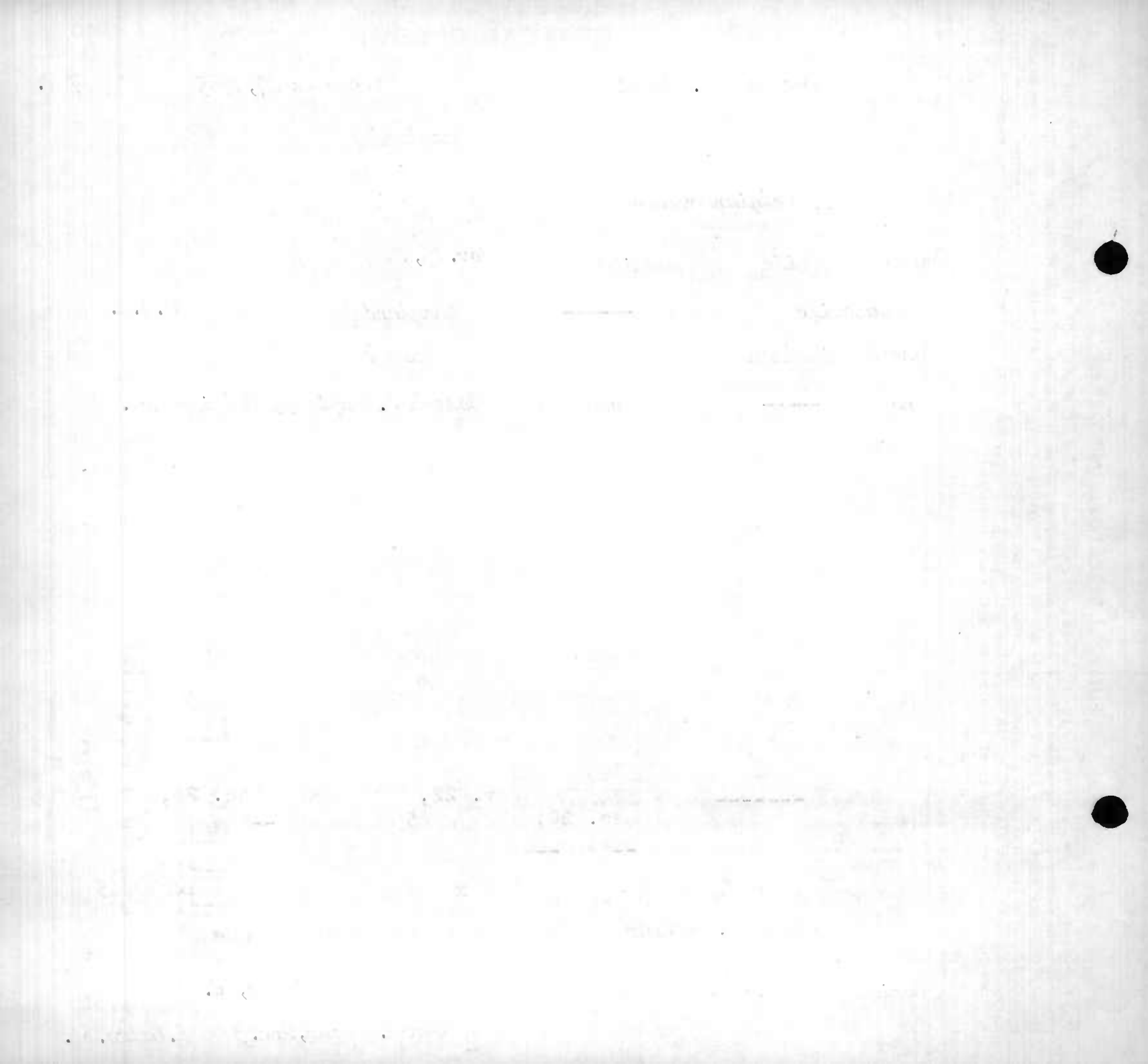
| BIRTH NO. 65 13467 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13467 | |
|--|------------------|---|---------------------------------|--|-----------------------------|---|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) EDWARD A. KRAMER, SR. | | | | 2. DATE AND HOUR OF DEATH 30 December 1965 10 ⁰⁰ M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION U.S. PUBLIC HEALTH SERVICE HOSP | | (If not in hospital or institution, give street address or location) BALTIMORE, MD. | | A. STATE MARYLAND | | B. COUNTY BALTIMORE CITY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MD. | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3410 Noble Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 28 MAR 1885 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARMY SERGEANT | | 10B. KIND OF BUSINESS OR INDUSTRY U.S. ARMY | | 11. BIRTHPLACE (State or foreign country) WISCONSIN | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John KRAMER | | | | 14. MOTHER'S MAIDEN NAME ZEILTER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1907-1937 | | 16. SOCIAL SECURITY NO. 220220003 | | 17. INFORMANT HOSPITAL RECORDS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I CARDIAC ARRHYTHMIA | | | | INTERVAL BETWEEN ONSET AND DEATH DAYS | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II ARTERIOSCLEROTIC HEART DISEASE YEARS | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | |
| 21D. TIME OF INJURY (APPROX.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> N/A Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? N/A | | | |
| 22. I certify that (this hospital) attended the deceased from 12/23 1965 to 12/30 1965, that (I) last saw the deceased alive on 12/30 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Jay M. Whitworth | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/30/65 | |
| 23C. PHYSICIAN'S NAME (Type) JAY M. WHITWORTH | | | | 23D. ADDRESS USPHS HOSP. 31 st WYMAN PK DR., BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/31/66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery, Baltimore, Maryland | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13468 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13468 | |
|---|-------------------------|--|---|--|--|
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <i>Barbara M. Haupt</i> | | | December 29, 1965 7 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>833 Belgian Avenue</i> | | | A. STATE <i>Maryland</i> B. COUNTY <i>27-10</i> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>833 Belgian Avenue</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i> | 8. DATE OF BIRTH <i>Nov. 15, 1889</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Joseph Reiselman</i> | | | 14. MOTHER'S MAIDEN NAME <i>Anna ?</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>unknown</i> | 17. INFORMANT ADDRESS <i>Joseph F. Haupt 833 Belgian Ave.</i> | | |
| 18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Hypertension</i> DUE TO <i>Arteriosclerotic cardiovascular disease</i> (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i> <i>10 yrs.</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 22, 1960</i> to <i>Dec. 29, 1965</i> , that (I) (we) last saw the deceased alive on <i>Dec. 20, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Lloyd E. Saylor</i> | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>12/30/65</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>Lloyd E. Saylor</i> | | | 23D. ADDRESS <i>3902 Greenmount Avenue</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/31/65</i> | 24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farber M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 3000 E. Balto. St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

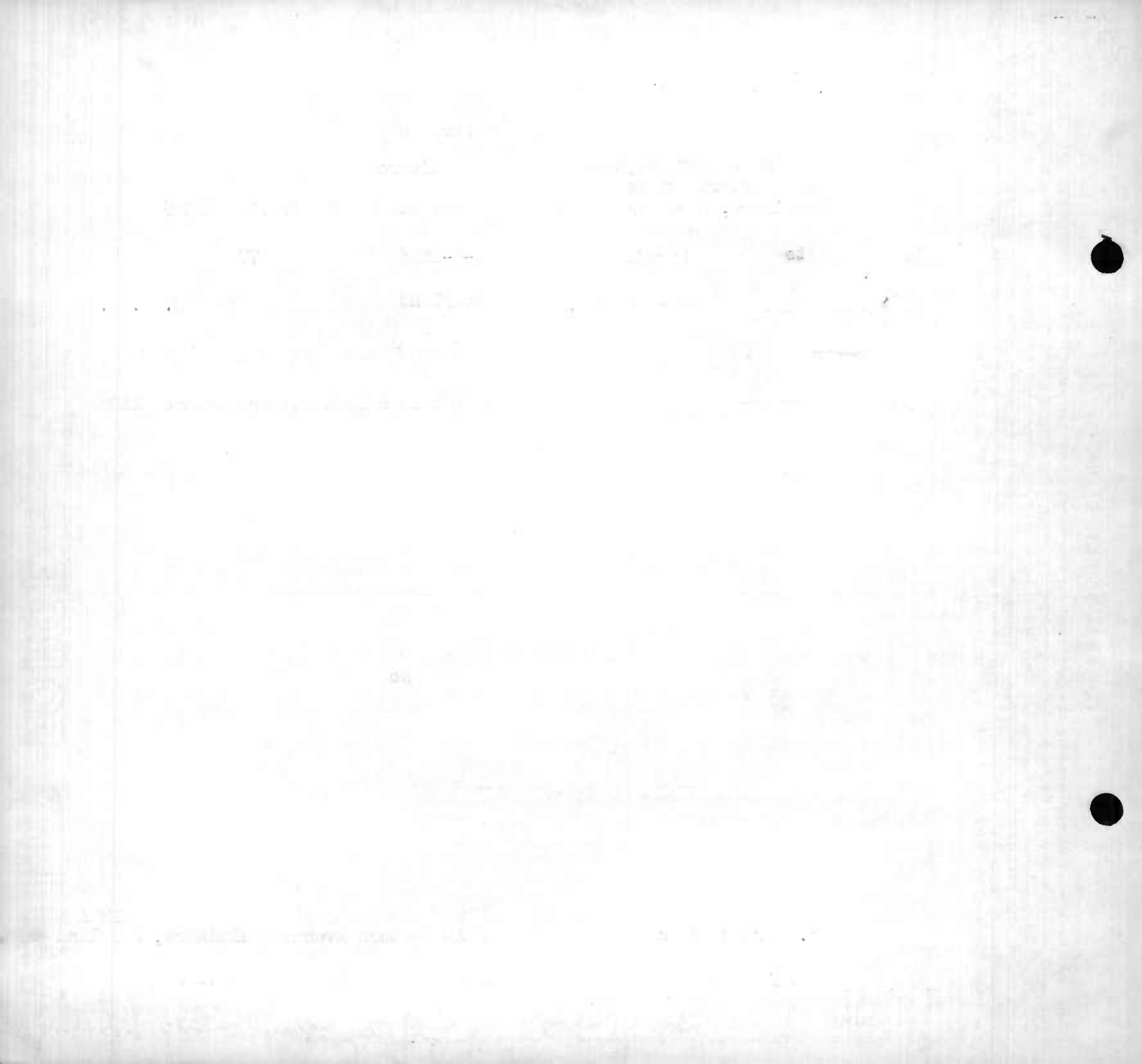
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|------------------------------|--|---|
| BIRTH NO. 65 13469 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13469 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 2 | |
| 1. NAME OF DECEASED (Type or Print) CLAUDE THOMPSON | | 2. DATE AND HOUR OF DEATH 12/28/65 | | 1:00 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 601 N BRO ADWAY 21205 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL 3200 | | | |
| | | D. STREET ADDRESS (If rural, give location) CHURCHTON MD | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2/12/12/ | 9. AGE (In years lost birthday) 53 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME CHARLES HENRY | | 14. MOTHER'S MAIDEN NAME MARY E. THOMPSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-43096 | | 17. INFORMANT Genera Thompson Churchton | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 592X I DUE TO (A) <i>Uremia</i> (B) <i>Chronic glomerulonephritis</i> (C) _____ | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH months years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GI Bleeding | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>DECEMBER 17</i> 19 <i>65</i> to <i>DECEMBER 28</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>DECEMBER 28</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Nicholas J. Fortuin</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) NICHOLAS J. FORTUIN | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL 601 N BROADWAY, 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-31-65 | | 24C. NAME OF CEMETERY or CREMATORY Franklin | |
| 24D. LOCATION (City, town, or county) (State) Churchton Md | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>William Reese # Anna</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|-------------------------------------|---|---|--|--|
| 44-97-98 FR 240 | | BIRTH NO. 65 13470 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13470 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JAMES J. WASHEL | | | | 2. DATE AND HOUR OF DEATH Dec 28/65 3:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2227 Jefferson Street 21205 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5-8-1888 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10B. KIND OF BUSINESS OR INDUSTRY SHIPYARD | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Andrew HENRY WASHEL | | | | 14. MOTHER'S MAIDEN NAME TEOFILA KUCZYNSKA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | | | |
| 18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Cancer of the Lung DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| | | | | (B) _____ DUE TO | | | |
| | | | | (C) _____ DUE TO | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 18 19 65 to Dec 27 19 65 , that (I) (we) last saw the deceased alive on Dec 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. Gerald Posen | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Dec 29/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Gerald Posen | | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12-31-65 | | 24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEM. | | 24D. LOCATION (City, town, or county) (State) BALTO, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Stanley Miller - 2534 Jefferson St. | | ADDRESS | |



1
E-363

65 13471

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 13471

BIRTH NO.

M.E. CASE NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| CHARLES EDWARDS | | December 27, 1965 11:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY JAIL | | A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1209 E. Federal Street | |

| | | | | | |
|---|------------------|--|--------------------------------|--|---|
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Jan 6 1940 | 9. AGE (In years last birthday) 25 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) DeKalb, Mississippi | |
| 13. FATHER'S NAME Leslie Edwards | | 14. MOTHER'S MAIDEN NAME Alice | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) Yes Korean Conflict | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Alice Edwards 1209 E. Federal St | |

| | | |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary sclerosis | | |
| (A) DUE TO | | |
| (B) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty liver and chronic pancreatitis | | |

| | | | |
|--|---|--|---|
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

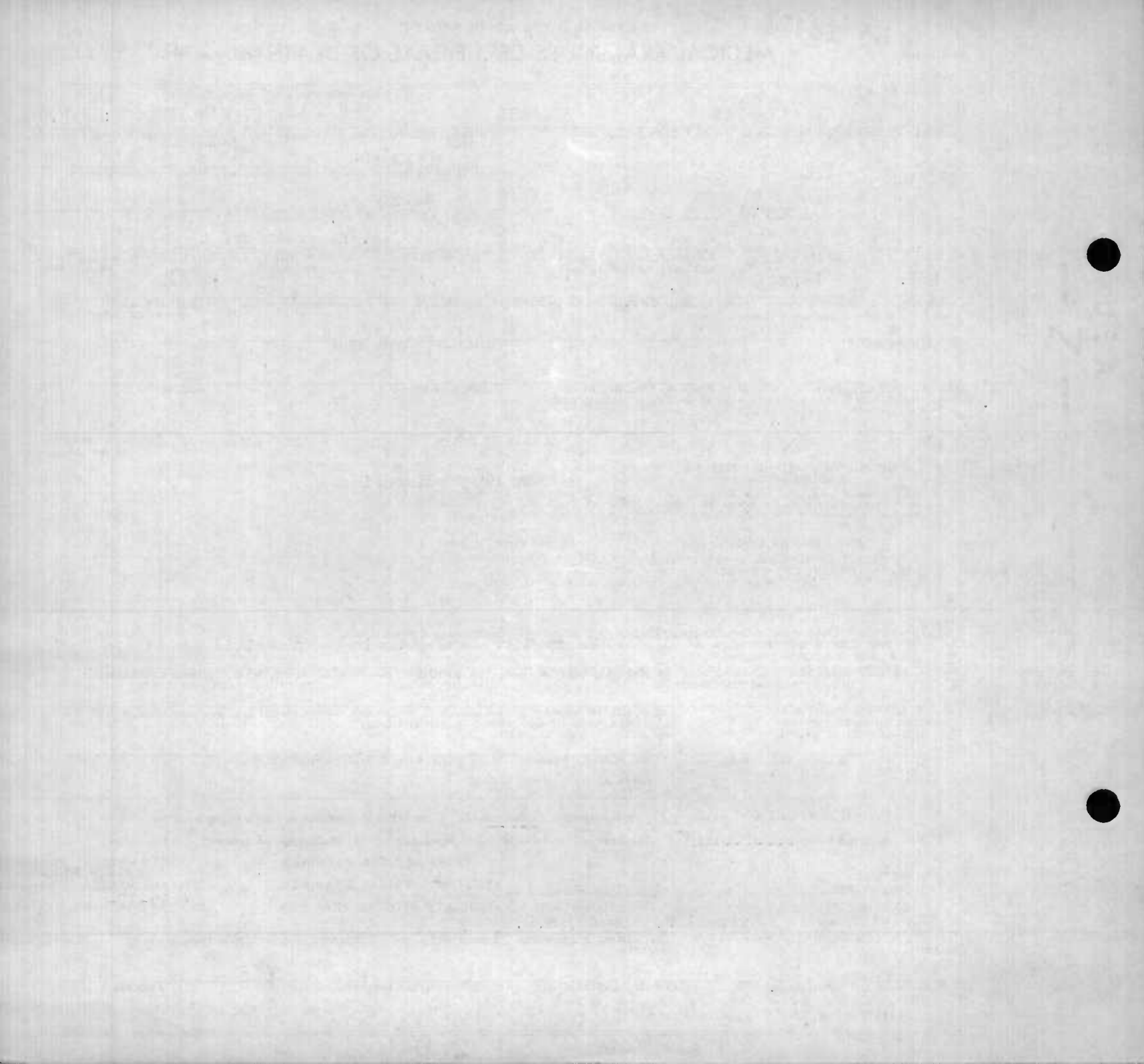
ACTUAL SIGNATURE: Russell S. Fisher, M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12-27-65

| | | | |
|--|--|--|--|
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE Dec 31/65 | 23C. NAME OF CEMETERY or CREMATORY Balt. Nat. Cem. | 23D. LOCATION (City, town, or county) (State) 5501 Frederick Ave. |
| 24A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. | 24C. FUNERAL DIRECTOR ADDRESS Milton E. Elickson 1129 N. Carroll St | |

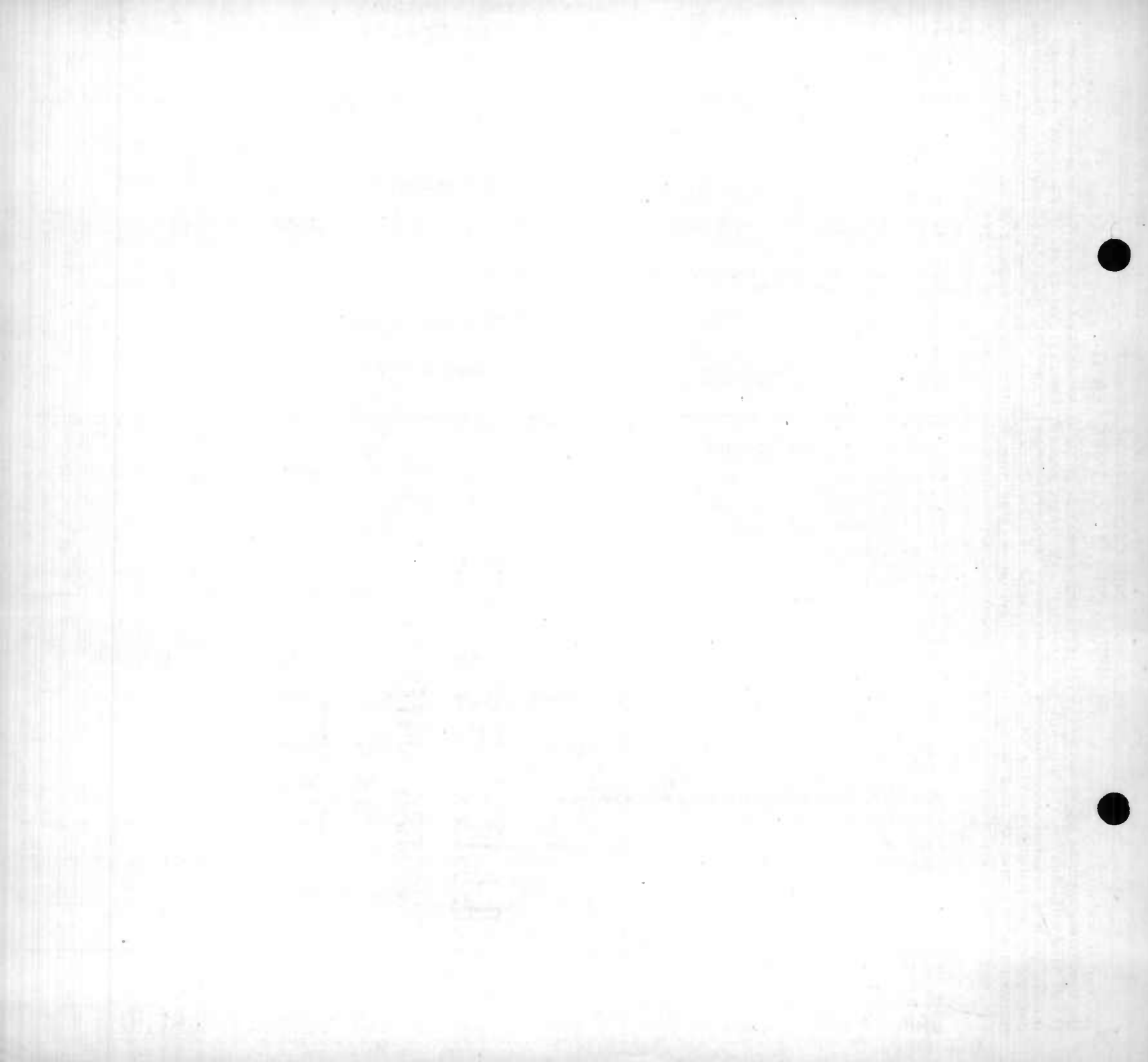
1 9 6 5 0 0 1 2 0 8 1



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

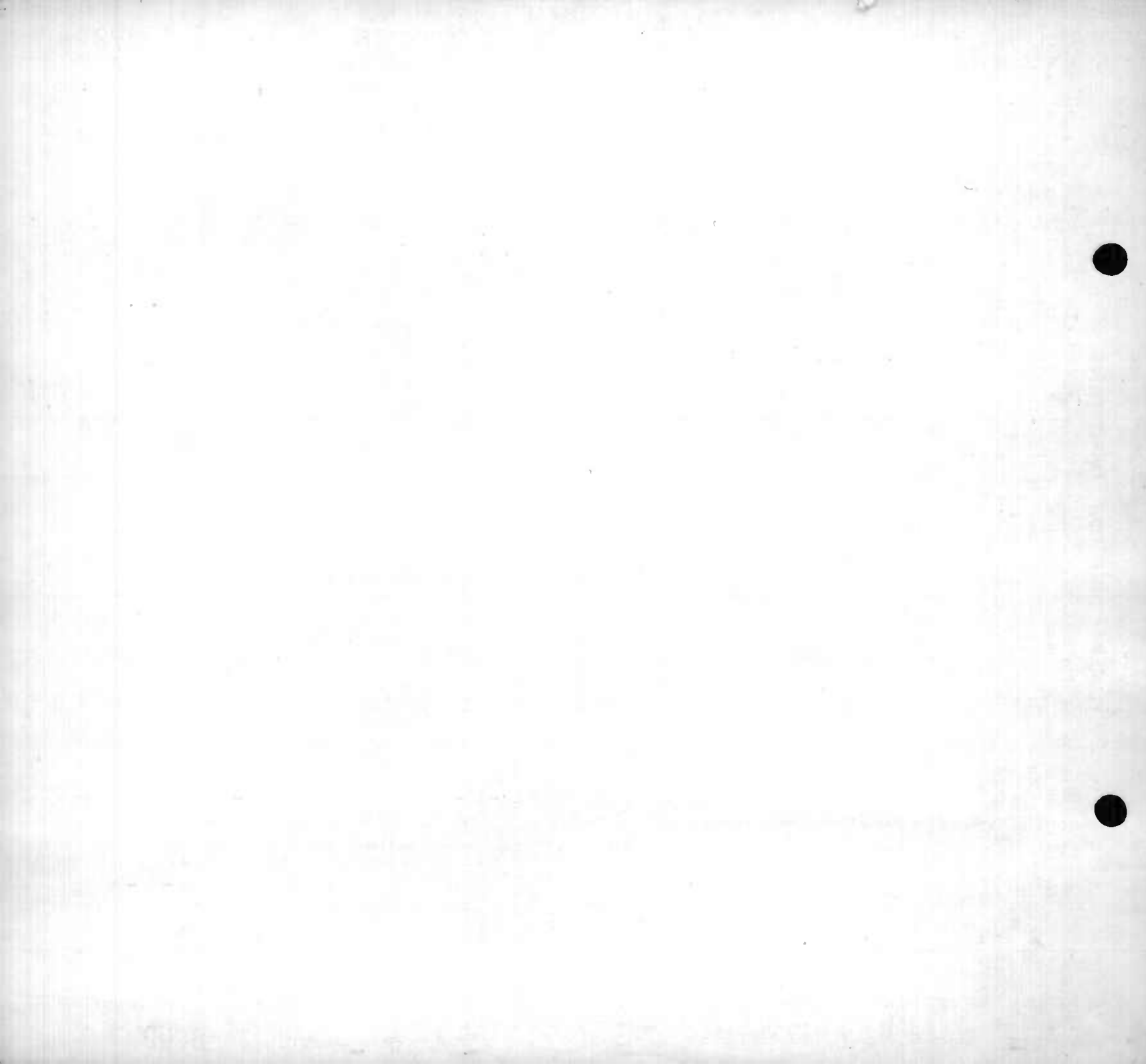
| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 65 13472 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13472 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) William Hopkins | | 2. DATE AND HOUR OF DEATH 12/19/65 11:05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 94 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 52-00 | |
| 5. SEX M | | 6. RACE N | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | |
| 8. DATE OF BIRTH unk. | | 9. AGE (In years lost birthday) 83 | | 10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME unk. | | 14. MOTHER'S MAIDEN NAME unk. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, bronchopneumonia bilat. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION 12/18/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED bronchostomy | |
| 19C. DATE OF OPERATION 12/18/65 | | 19D. CONDITION FOR WHICH OPERATION WAS PERFORMED bronchostomy | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, (street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from 12/15/65 to 12/19/65, that (we) lost saw the deceased alive on 12/19/65 and that (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 23A. SIGNATURE Bernard du Buy M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) Bernard du Buy M.D. | | 23D. ADDRESS University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 12-28-65 | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

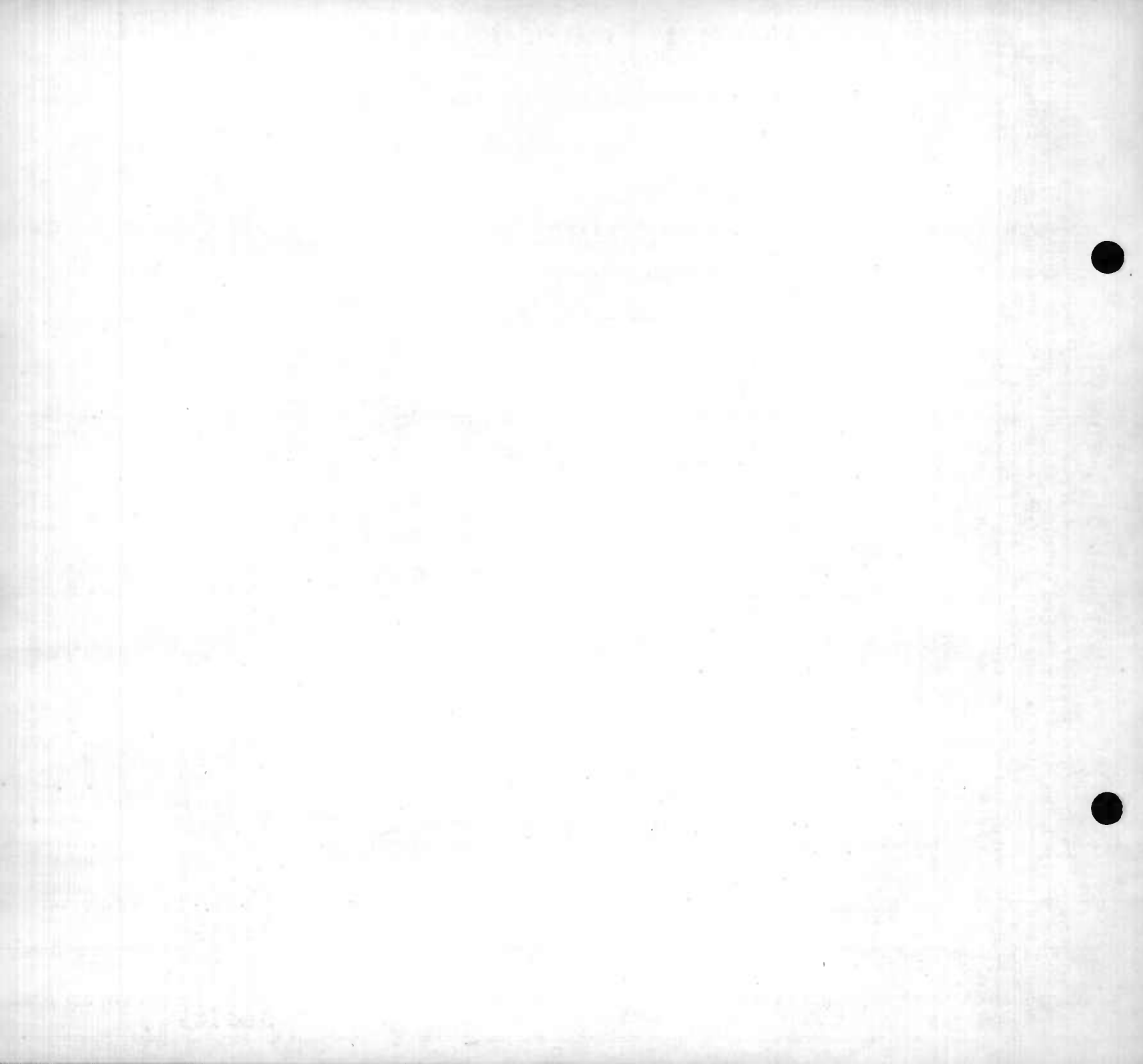
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13473 | |
|--|--|--|--|--|--|
| BIRTH NO. 65 13473 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Baby of Alice Day | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | 2. DATE AND HOUR OF DEATH December 19, 1965 1:10 PM. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| Provident Hospital 1514 Division Street Baltimore, Maryland | | Maryland | | Baltimore | |
| 5. SEX Male | | 6. RACE Negro | | D. STREET ADDRESS (If rural, give location) | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH 12-19-65 | | 2038 Linden Avenue | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years lost birthday) | |
| | | | | 12 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | U.S. | |
| 13. FATHER'S NAME Hamlet Day | | 14. MOTHER'S MAIDEN NAME Alice Day | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | (A) Due to Maxine Pulmonary Atelectasis | | | |
| ANTECEDENT CAUSES | | (B) Due to Immaturity | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-19-1965 to 12-19-1965, that (I) (we) lost saw the deceased alive on 12-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Lionel C. Rose | | 23B. DATE SIGNED 12-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) Lionel C. Rose | | 23D. ADDRESS 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 12-28-65 | | 24C. NAME OF CEMETERY | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | | | MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|---|---|
| <p>BIRTH NO. 65 13474</p> <p>CERTIFICATE OF DEATH</p> | | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>Registered No. 65 13474 4</p> | |
| <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) BABY BOY GRAHE</p> | | <p>2. DATE AND HOUR OF DEATH DEC. 9, 1967 2:45 P.M.</p> | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY</p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY SEVERNA PARK</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 52-00</p> <p>D. STREET ADDRESS (If rural, give location) CORPUS RD. BOX 172 B</p> | |
| <p>5. SEX MALE</p> | <p>6. RACE WHITE</p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) INFANT</p> | <p>8. DATE OF BIRTH 12/9/67</p> |
| <p>9. AGE (In years last birthday) 1</p> | | <p>10. If Under 1 Yr. Months Days 1 12</p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> | |
| <p>11. BIRTHPLACE (State or foreign country) MARYLAND</p> | | <p>12. CITIZEN OF WHAT COUNTRY? USA</p> | |
| <p>13. FATHER'S NAME JOHN WESLEY GRAHE</p> | | <p>14. MOTHER'S MAIDEN NAME EVELYN ?</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> | | <p>16. SOCIAL SECURITY NO.</p> | |
| <p>17. INFORMANT</p> | | <p>ADDRESS</p> | |
| <p>18. 773.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> | | <p>CAUSE OF DEATH</p> <p>(A) Respiratory Arrest DUE TO</p> <p>(B) of UNDETERMINED ORIGIN DUE TO</p> <p>(C) _____</p> | |
| <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | <p>INTERVAL BETWEEN ONSET AND DEATH</p> | |
| <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | |
| <p>19A. DATE OF OPERATION</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | |
| <p>20A. AUTOPSY? (Yes or No)</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 12/9 19 67 to 12/9 19 67, that (I) (we) last saw the deceased alive on 12/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE <i>Victoria T. Maisog</i></p> | | <p>23B. DATE SIGNED 12/9/67</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) VICTORIA T. MAISOG</p> | | <p>23D. ADDRESS ANATOMY DEPARTMENT OF MARYLAND UNIVERSITY MEDICAL SCHOOL</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> | | <p>24B. DATE 12-28-67</p> | |
| <p>24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL</p> | | <p>24D. LOCATION (City, town, or county) (State)</p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966</p> | | <p>25B. NAME OF REGISTRAR Robert E. Fairbank</p> | |
| <p>25C. FUNERAL DIRECTOR MORTUARY SERVICE</p> | | <p>ADDRESS BCUD</p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13475 | |
|---|-----------------------|--|--------------------------------------|--|--|
| BIRTH NO. 65 13475 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Baby Bay Walker</i> | | 2. DATE AND HOUR OF DEATH <i>14 Dec 65 4:15 AM</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | A. STATE <i>B Maryland</i> B. COUNTY <i>25-32</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>5721 Round Rd</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>Neg</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>N.M.</i> | 8. DATE OF BIRTH <i>14 Dec 65</i> | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <i>50</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Matthew Norman Walker</i> | | 14. MOTHER'S MAIDEN NAME <i>Carol Ann Witten</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT ADDRESS <i>Mother</i> | |
| 18. <i>754.5 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <i>Congenital Heart Disease</i> (B) DUE TO <i>Cardiac Decompensation</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>Birth</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>D</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>14 Dec 65</i> 19 to <i>14 Dec</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>14 Dec</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Donald E. Krickubaer</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>14 Dec 65</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>12-28-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>ANATOMY BOARD OF MARYLAND</i> | |
| 24D. LOCATION (City, town, or county) | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Bailey</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>UNIVERSITY MEDICAL SCHOOL</i> | |
| MORTUARY SERVICE - BCHD | | | | | |

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M. J.
Copyrighted by the
Author of the

North American

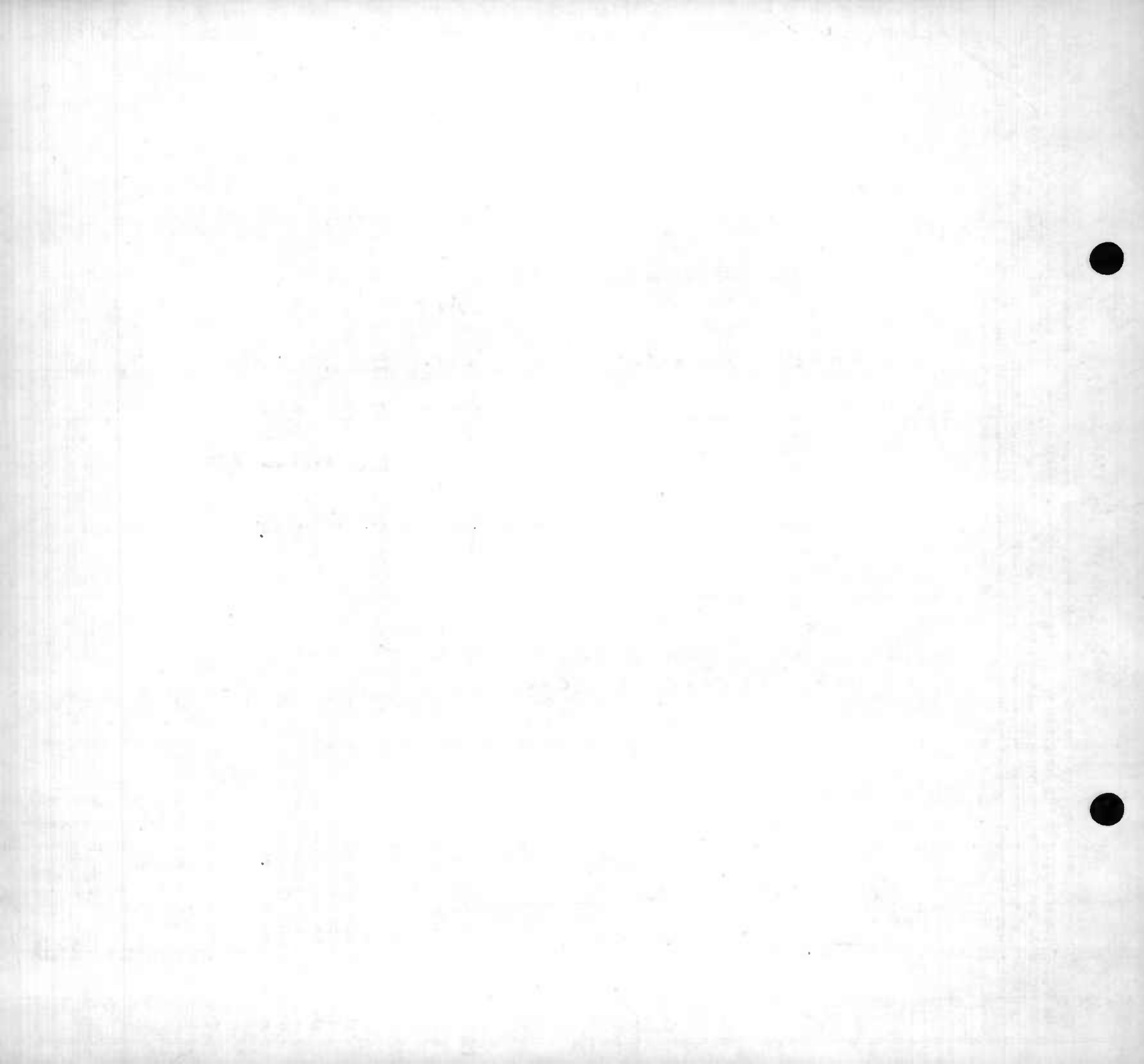
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Author of the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

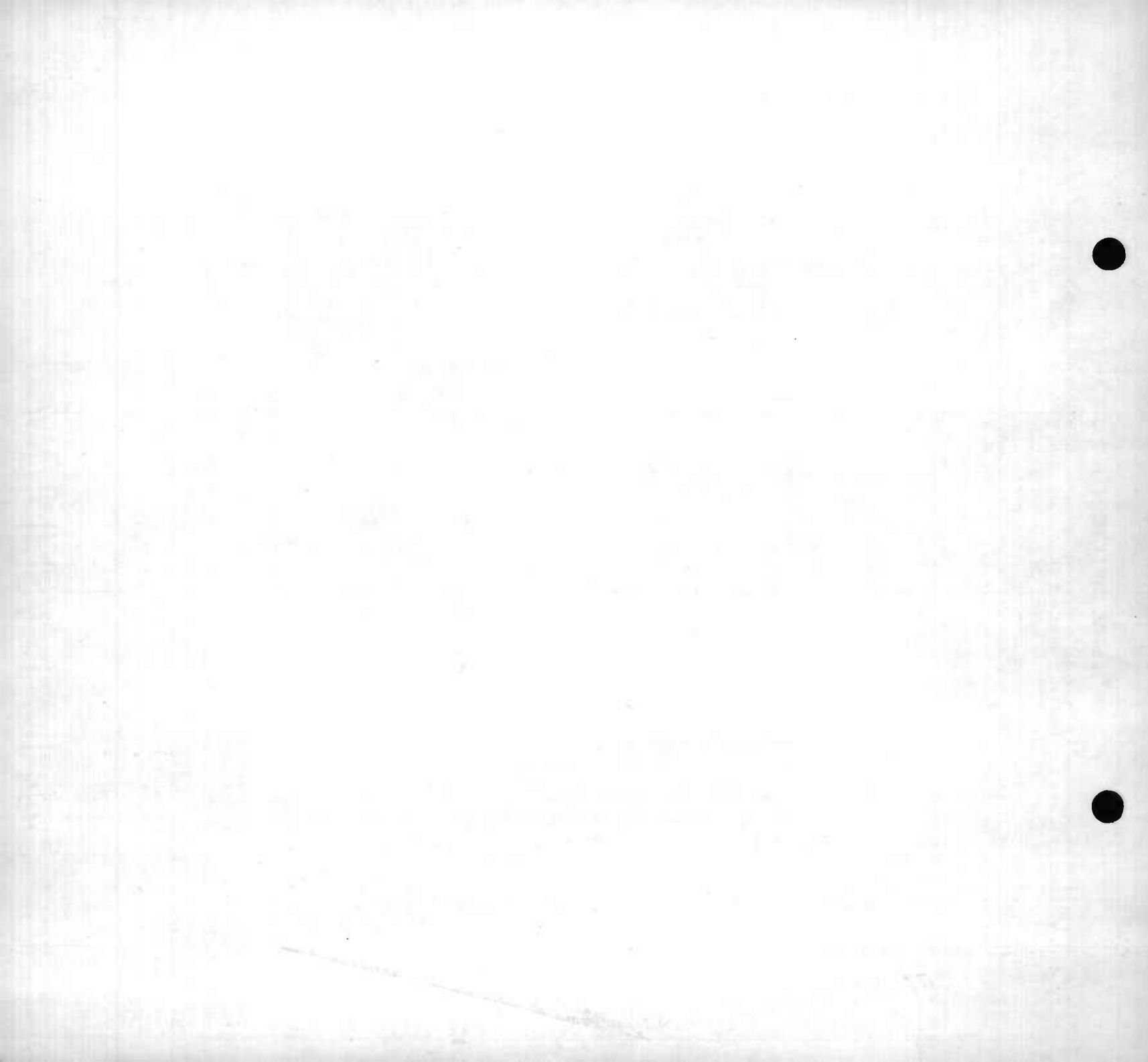
| | | | | | |
|--|---------------------|---|------------------------------------|---|---|
| BIRTH NO. <u>65-30432</u> <u>65</u> <u>13476</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65</u> <u>13476</u> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>BABY BOY RICHARDSON</u> | | 2. DATE AND HOUR OF DEATH <u>12/6/65</u> <u>1945</u> <u>AM.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u> <u>9-9</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSP.</u> | | D. STREET ADDRESS (If rural, give location) <u>1539 HOLBROOK ST.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>12/3/65</u> | 9. AGE (In years lost birthday) <u>0</u> <u>6</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>CLAUDE RICHARDSON</u> | | 14. MOTHER'S MAIDEN NAME <u>ALMA J. JOHNSON</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>0</u> | | 17. INFORMANT ADDRESS <u>UNIV. HOSP. Chd # 3284-64.</u> | |
| 18. <u>751.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Brain Stem Hemorrhage</u> | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO <u>Hydrocephalus</u> | | <u>?</u> | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>3/12/3/65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>HEMINGOMYCELOCELE</u> | | 20A. AUTOPSY (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>Dr.</u> (this hospital) attended the deceased from <u>12/3</u> <u>1965</u> to <u>12/6</u> <u>1965</u> , that <u>Dr.</u> (we) last saw the deceased alive on <u>12/6</u> <u>1965</u> and that <u>Dr.</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>Dr.</u> (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Albert M. Gordon</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>12/6/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ALBERT M. GORDON</u> | | 23D. ADDRESS <u>UNIVERSITY HOSPITAL</u> <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>12-28-65</u> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY <u>CITY DISPOSITION</u> | |
| 24D. LOCATION <u>UNIVERSITY MEDICAL SCHOOL</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u> | | 25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

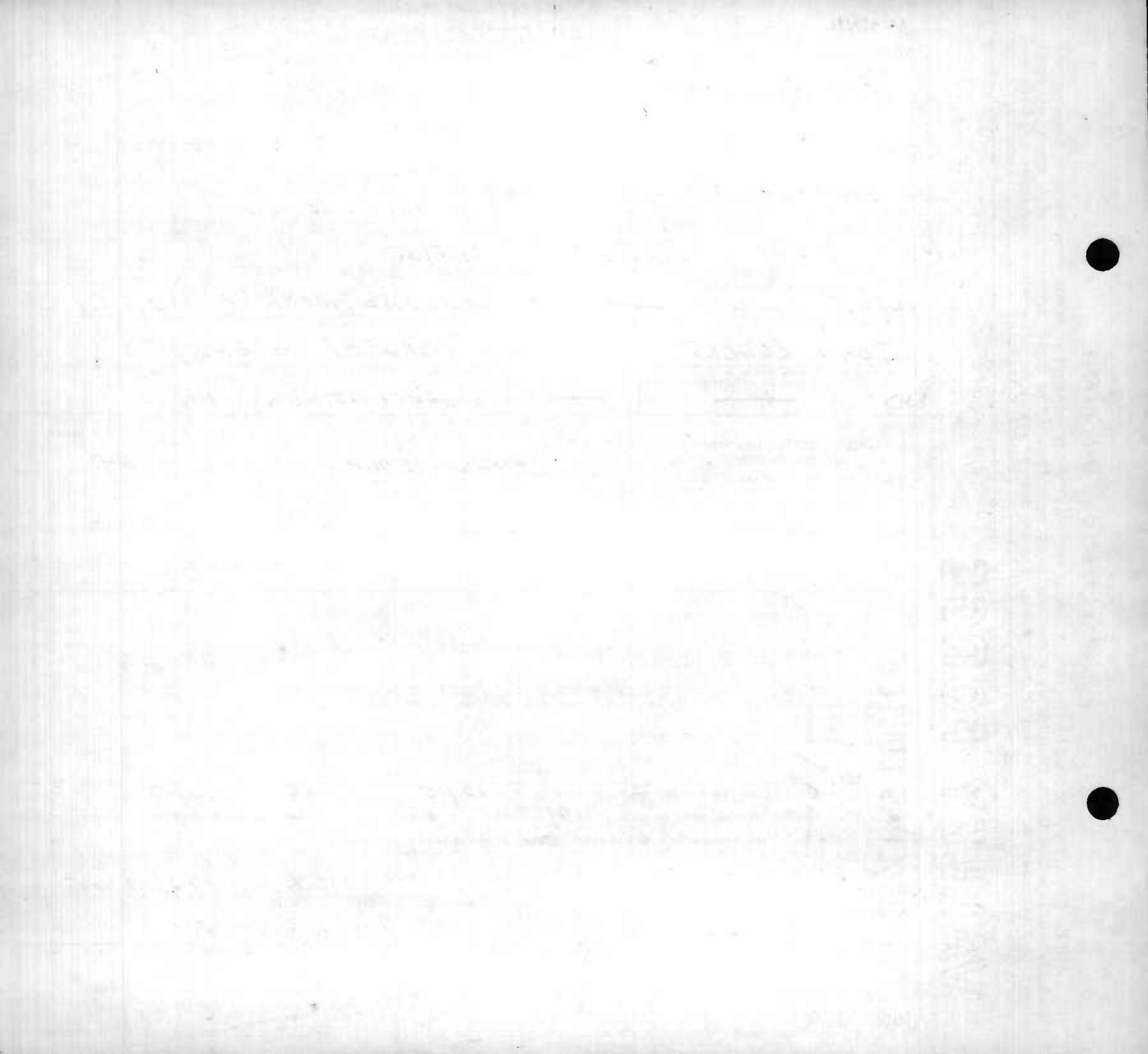
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 13477 | |
|--|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. 65 30433 | | 65 13477 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>YORK, Baby Girl</u> | | 2. DATE AND HOUR OF DEATH <u>12/13/65</u> <u>3 40</u> <u>AM.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Md. Hosp.</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>-16-08</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1008 Augusta Ave (#29)</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u> | 8. DATE OF BIRTH <u>12/11/65</u> | 9. AGE (In years lost birthday) <u>0</u> | 10. If Under 1 Yr. Months Days <u>1</u> <u>9</u> <u>50</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Robert Syukes</u> | | 14. MOTHER'S MAIDEN NAME <u>Elvira York</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Chant (mother)</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>760.51</u> | | CAUSE OF DEATH (A) <u>Respiratory Distress Syndrome</u> DUE TO (B) <u>Intra cranial hemorrhage</u> DUE TO (C) <u>Prematurity</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>life</u> <u>life</u> <u>life</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>8</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>12/11/65</u> to <u>12/13/1965</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/11/65</u> to <u>12/13/1965</u> that (I) (we) last saw the deceased alive on <u>12/13/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>MC [Signature]</u> | | 23B. DATE SIGNED <u>12/13/65</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Univ. of Md. Hosp. Balto.</u> | |
| 23D. ADDRESS <u>Univ. of Md. Hosp. Balto.</u> | | 23E. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u> | | 23F. ADDRESS <u>—</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CITY REMOVAL</u> | | 24B. DATE <u>12-28-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD</u> | |
| 24D. LOCATION <u>UNIVERSITY MEDICAL SCHOOL</u> | | 24E. CITY, TOWN, or county <u>BALTIMORE</u> | | 24F. STATE <u>MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u> | | 25C. ADDRESS <u>—</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

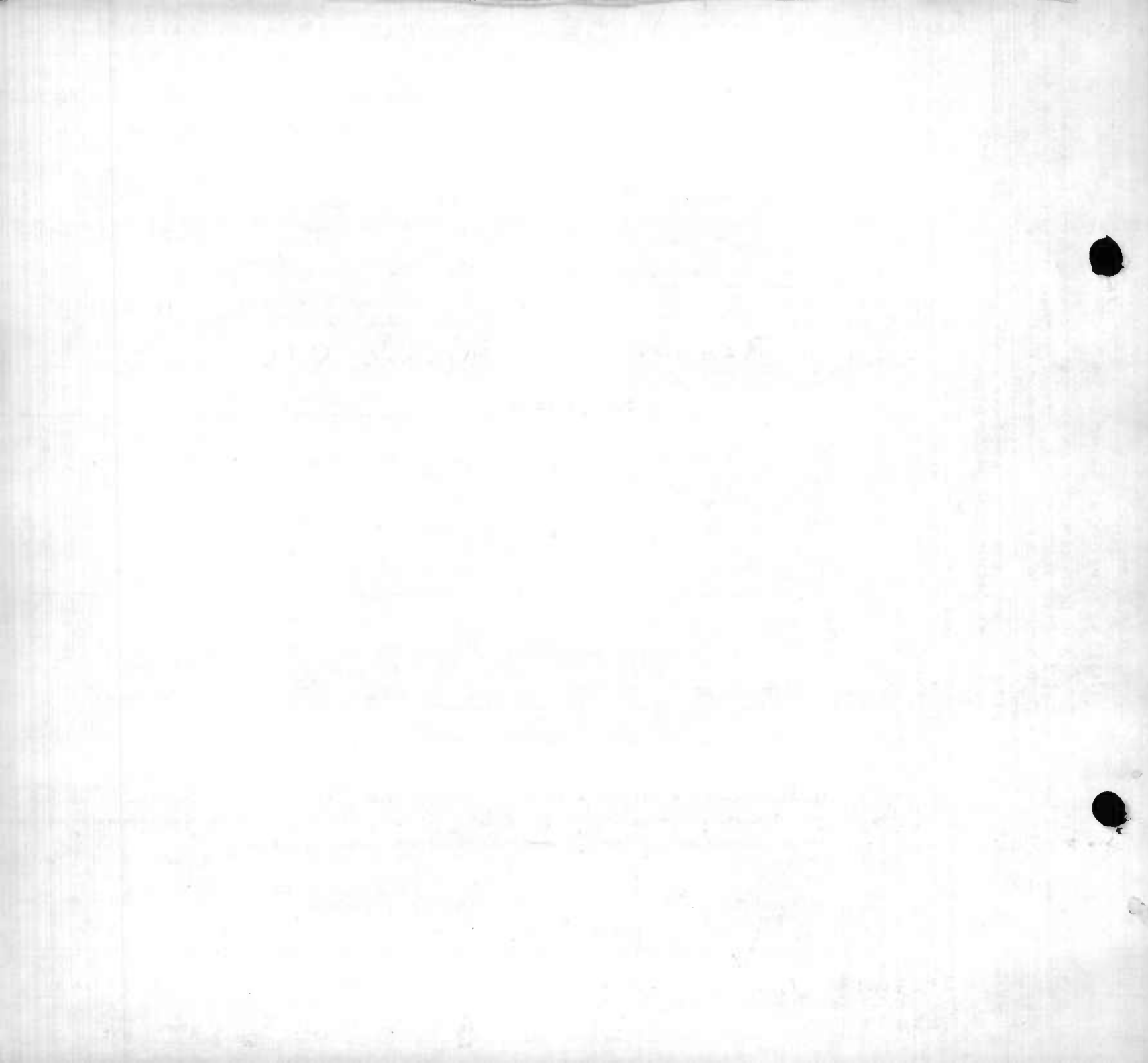
| | | | | | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 65-31374 65 13478 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13478 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BABY BOY CONORT | | | 2. DATE AND HOUR OF DEATH 12/17/65 5:00 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1608 OLIVE ST. | | |
| 5. SEX M | 6. RACE CAUC. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 12/15/65 | 9. AGE (In years last birthday) 2 | If Under 1 Yr. Months: 2 Days: 2 Hours: 2 Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME JOHN CONORT | | | 14. MOTHER'S MAIDEN NAME DOROTHY GLEASON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS CHART (MOTHER) (ABOVE) | |
| 18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HYPOGLYCEMIA DUE TO PERINATAL ANOXIA DUE TO CONCEALED HEMORRHAGE PLACENTAS INTRAUTERINE (LIFE PLUS) | | | INTERVAL BETWEEN ONSET AND DEATH 24⁶ LIFE | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 12/15 19 65 to 12/17 19 65 , that (2) (we) last saw the deceased alive on 12/17 19 65 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Mitchell Sollod M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 12/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) MITCHELL SOLLOD M.D. | | 23D. ADDRESS UNIVERSITY MEDICAL SCHOOL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 22865 | | 24B. DATE 12/28/65 | | 24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND | |
| 24D. LOCATION (City, town, or county) BALTIMORE | | 24E. (State) MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

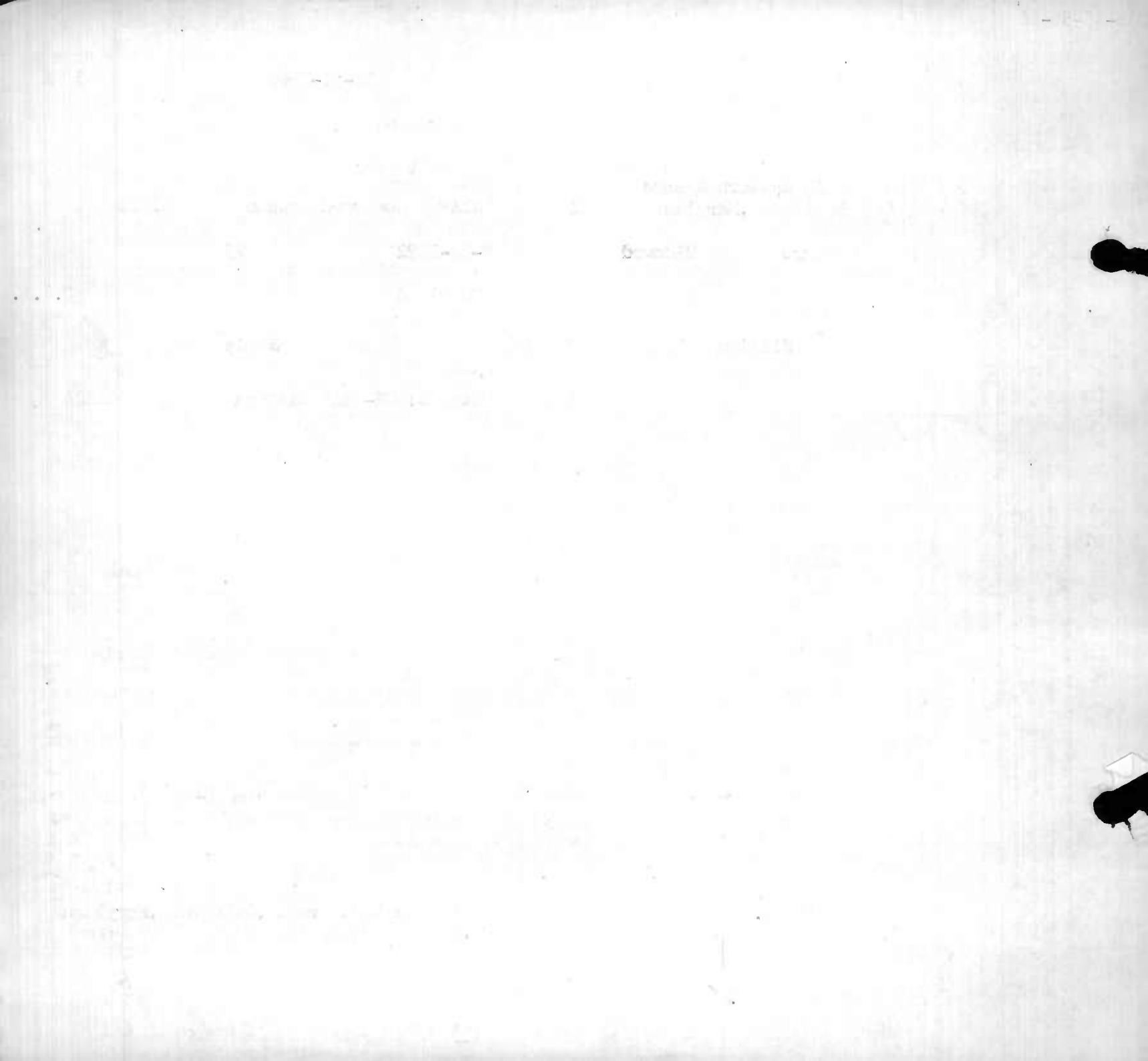
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 65 13479 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | | 65 13479 | |
|---|-------------------------|---|--|--|--|---|---|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Cynthia S. Rennick</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/31/65 11:00 AM</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | A. STATE <i>MARYLAND</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI HOSPITAL OF BALTIMORE, INC.</i> | | | | B. COUNTY <i>BALTIMORE</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>DUNDALK 53-00</i> | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>122 SOLLERS POINT ROAD</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>NEGRO</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>SINGLE</i> | 8. DATE OF BIRTH <i>3/31/42</i> | 9. AGE (In years last birthday) <i>23</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SOCIAL WORKER</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>NORTH CAROLINA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | |
| 13. FATHER'S NAME <i>John H. Rennick</i> | | | 14. MOTHER'S MAIDEN NAME <i>Minnie Cole</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | |
| 16. SOCIAL SECURITY NO. <i>216-42-2598</i> | | | 17. INFORMANT <i>HOSPITAL CHART</i> | | | ADDRESS | | | |
| 18. <i>525X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>PULMONARY DIFFUSION FIBROSIS</i> | | | | CAUSE OF DEATH (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH <i>5 mos</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | |
| (C) DUE TO | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (this hospital) attended the deceased from <i>NOV. 10, 1965</i> to <i>DEC. 31, 1965</i> , that (I) lost saw the deceased alive on <i>DEC. 31, 1965</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Gerald A. Hoffman</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12/31/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>GERALD A. HOFFMAN</i> | | | | M.D. | | 23D. ADDRESS <i>SINAI HOSP., BALTO. MD.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>1/6/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Westview Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Wadesboro, North Carolina</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fadden</i> | | 25C. FUNERAL DIRECTOR <i>The Mother & Yett Funeral Home Inc.</i> | | ADDRESS | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

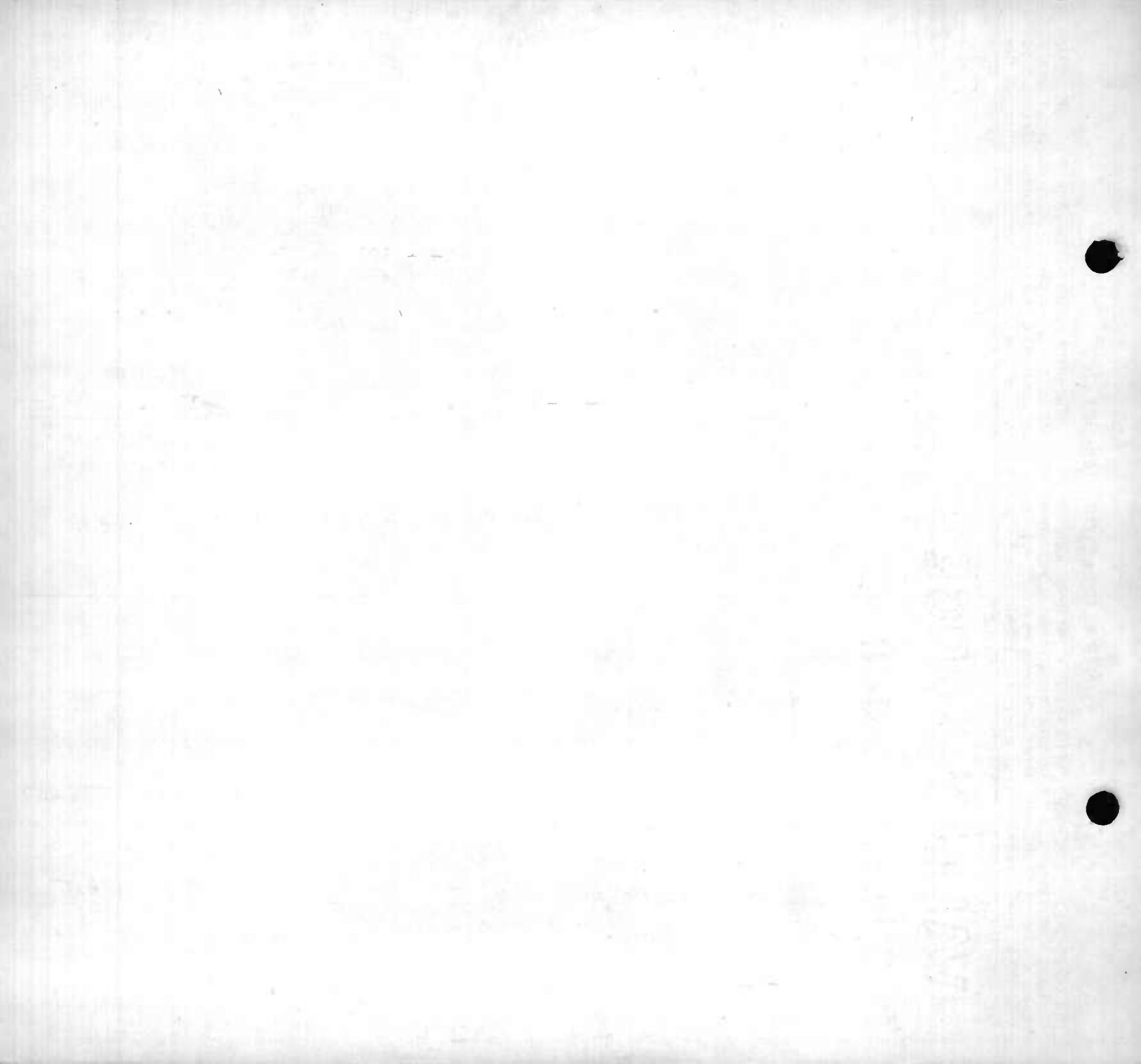
| | | | | | |
|--|------------------|---|-------------------------------|--|--|
| C-462 65 13480 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13480 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 12-31-1965 3 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Maryland B. COUNTY 9-08 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | Baltimore | | 2149 Homewood Avenue 21218 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8-22-1892 | 9. AGE (In years lost birthday) 73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME William - Solomon Clark | | 14. MOTHER'S MAIDEN NAME Susie Thomas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-05-9432 | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 177X I CAUSE OF DEATH Carcinoma of the Prostate (A) DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 yrs | | ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C) Anemia, cachexia 6 mos | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION Jan 63 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/22 1965 to 3AM, 12/31 1965, that (I) (we) last saw the deceased alive on 12/31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John C. Wade | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/31/65 | |
| 23C. PHYSICIAN'S NAME (Type) John C. Wade | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland | | M.O. THE Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-4-66 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn | |
| 24D. LOCATION Ba No | | 24E. (City, town, or county) Md. | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS MORTON & DGETT - 1701 LAURENS ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13481 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13481 | |
|--|-------------------------|--|---|--|---|---|---|-------------------------|--|
| 1. NAME OF DECEASED (Type or Print) JERRY CARMICHAEL | | | | 2. DATE AND HOUR OF DEATH December 30, 1965 8:05 M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PROVIDENT HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 12 NORTH BENTALOU STREET | | | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH SEPT-6- 1915 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR CLEANER | | | 10B. KIND OF BUSINESS OR INDUSTRY R.R. RAILROAD | | 11. BIRTHPLACE (State or foreign country) NICHOLS, SOUTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME DANIEL CARMICHAEL | | | | 14. MOTHER'S MAIDEN NAME ESTELLE FORD | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 248-18-3726 | | 17. INFORMANT ADDRESS MRS. GOLDIE CARMICHAEL 12 N. Bentalou | | | | |
| 18. I 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY OCCLUSION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTERVAL BETWEEN ONSET AND DEATH Immediate | | | | (A) DUE TO Acute Coronary occlusion (B) DUE TO Hypertensive Cardio-Vascular disease (C) DUE TO years. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1959- 19 Dec. 18 19 65 , that (I) (we) last saw the deceased alive on Dec. 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Charles Tommasello M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED Dec. 31/65 | | |
| 23C. PHYSICIAN'S NAME (Type) Charles Tommasello | | | | 23D. ADDRESS 900 W. Lombard St. Balt. Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-3-66 | | 24C. NAME OF CEMETERY or CREMATORY NICHOLS CEMETERY | | 24D. LOCATION (City, town, or county) (State) NICHOLS, SOUTH CAROLINA | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS THE MORTON AND DYETT FUNERAL HOME INC | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

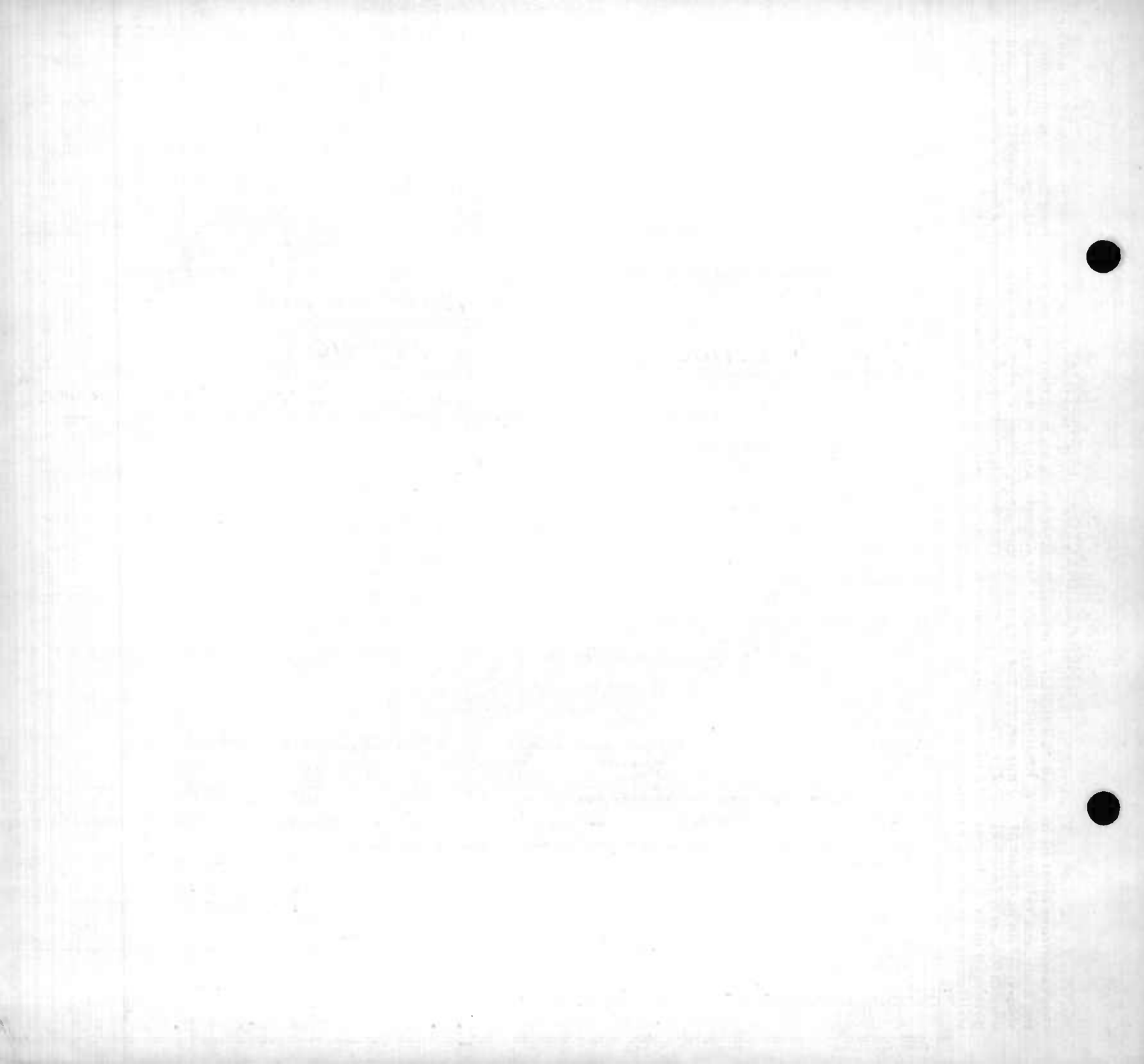
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|--|--|--|---|--|---|
| BIRTH NO. 65 13482 | | | | | REGISTERED NO. 65 13482 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ADDIE GUERLEY | | | | | 2. DATE AND HOUR OF DEATH 12/29/65 11:30 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1026 M'ALEER CT. | | | | |
| 5. SEX F | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9-20-1892 | 9. AGE (In years lost birthday) 73 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY WIDOWED | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME FRANK HENDERSON | | | | | 14. MOTHER'S MAIDEN NAME HENRIETTA JONES | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT GUSSIE MACK | | | | ADDRESS 1322 HARLEM AVE |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Anoxia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Artery occlusion Arteriosclerosis | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH several hours 1 or 2 days several yrs. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Previous Myocardial Infarction | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/29 1965 to 12/29 1965 , that (I) (we) last saw the deceased alive on 12/29/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE William Legat M.D. | | | | | 23B. DATE SIGNED 12/30/65 | | 23C. PHYSICIAN'S NAME (Type) M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE I-3-65 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore National Ct | | 24D. LOCATION (City, town, or county) (State) Baltimore, City | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. JAN 3 1966 | | | 25B. NAME OF REGISTRAR J. E. Brown | | | 25C. FUNERAL DIRECTOR I. E. Brown & Son | | | ADDRESS 108 W. Montgomery St. |

George Mark 1852-1853

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 13483 | | CERTIFICATE OF DEATH | | Registered No. 65 13483 | |
|--|---------------------|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MOSES, ELLEN | | | | 2. DATE AND HOUR OF DEATH 12/27/65 6:40 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1512 D. STREET ADDRESS (If rural, give location) 3922 PARK HEIGHTS AVE. | | | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 11/28/14 | | 9. AGE (In years last birthday) 51 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME JOHN VALENTINE | | | | 14. MOTHER'S MAIDEN NAME MAMIE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT JOHNNIE MOSES | | ADDRESS 3922 PARK Hgts AVE | | | |
| 18. 153.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) METASTATIC CARCINOMA DUE TO E GI BLEEDING (B) ADENO Ca OF SIGMOID COLON DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 9 MONTHS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2/2/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENO Ca OF SIGMOID COLON | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 12/24 19 65 to 12/27 19 65 , that (H) (we) last saw the deceased alive on 12/27 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Stanley Friedler | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/27/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) STANLEY FRIEDLER | | | | 23D. ADDRESS M.D. SINAI HOSP. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12-31-65 | | 24C. NAME of CEMETERY or CREMATORY Mount Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore City | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Philip E. Taylor | | 25C. FUNERAL DIRECTOR I. L. Brown and Son-108 w. Montgomery S | | | | ADDRESS | |



| | | | | | |
|---|---------|---|--|--|--|
| 65 13484 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 13484 | |
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| HENRY HUNT | | | December 27, 1965 12:15P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE Maryland B. COUNTY | | |
| 834 S. Hanover Street | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 834 S. Hanover Street | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Male | Negro | M | 2-14-90 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Baltimore | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Mary L. Hunt- 900 Hanover St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 422.1 I | | | Arteriosclerotic cardiovascular disease | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK NOT WHILE AT WORK | | | |
| | | | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER | | 12-27-65 | |
| Russell S. Fisher, M.D. | | ASSOCIATE MEDICAL EXAMINER | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | I-31-65 | | Baltimore National | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | |
| JAN 3 1966 | | Robert E. Fisher | | I.L. Brown and Son-108 W. Montgomery S | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------------|---|---|---|---|
| BIRTH NO. 65 13485 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13485 | |
| 1. NAME OF DECEASED (Type or Print) <i>Edwards, George</i> | | | 2. DATE AND HOUR OF DEATH <i>25-Dec-65</i> <i>4:00</i> P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>A. C.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie</i> D. STREET ADDRESS (If rural, give location) <i>Box 254</i> | | |
| 5. SEX <i>M</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>3-4-80</i> | 9. AGE (In years lost birthday) <i>85</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) — | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME — | | | 14. MOTHER'S MAIDEN NAME — | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>OK known</i> | | 16. SOCIAL SECURITY NO. — | 17. INFORMANT <i>Estelle (sister)</i> | | ADDRESS <i>s/a</i> |
| 18. <i>350X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Severe Dehydration</i> | | | (A) <i>Acute myocardial Infarction</i> DUE TO (B) <i>Parkinson's Disease</i> DUE TO (C) <i>Pneumonia</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>21 days</i> <i>many years</i> <i>11 days</i> |
| 19A. DATE OF OPERATION <i>12-17-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tracheotomy for respiratory distress</i> | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>17-Dec-65</i> to <i>25-Dec-65</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>25-December</i> 19 <i>65</i> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Bernard Pleet</i> 23C. PHYSICIAN'S NAME (Type) <i>Bernard Pleet</i> | | | | 23B. DATE SIGNED <i>25-Dec-65</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-30-65</i> | 24C. NAME of CEMETERY or CREMATORY <i>Hall's Church</i> | | 24D. LOCATION (City, town, or county) (State) <i>A. A. Co, MD</i> |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farber, MD</i> | | 25C. FUNERAL DIRECTOR <i>I. C. Brown & Son</i> | |
| ADDRESS <i>123 W. MONTGOMERY ST</i> | | | | | |

13-0-81

Travelling - to hospital and

Scout Expedition

Passenger

Particular 1st class

Great Western Railway

2/4 (100)

Revenue

Wages

18-2-84

82

100

Q. B. 100

Consolidated Hospital

22-10-81

22-10-81

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

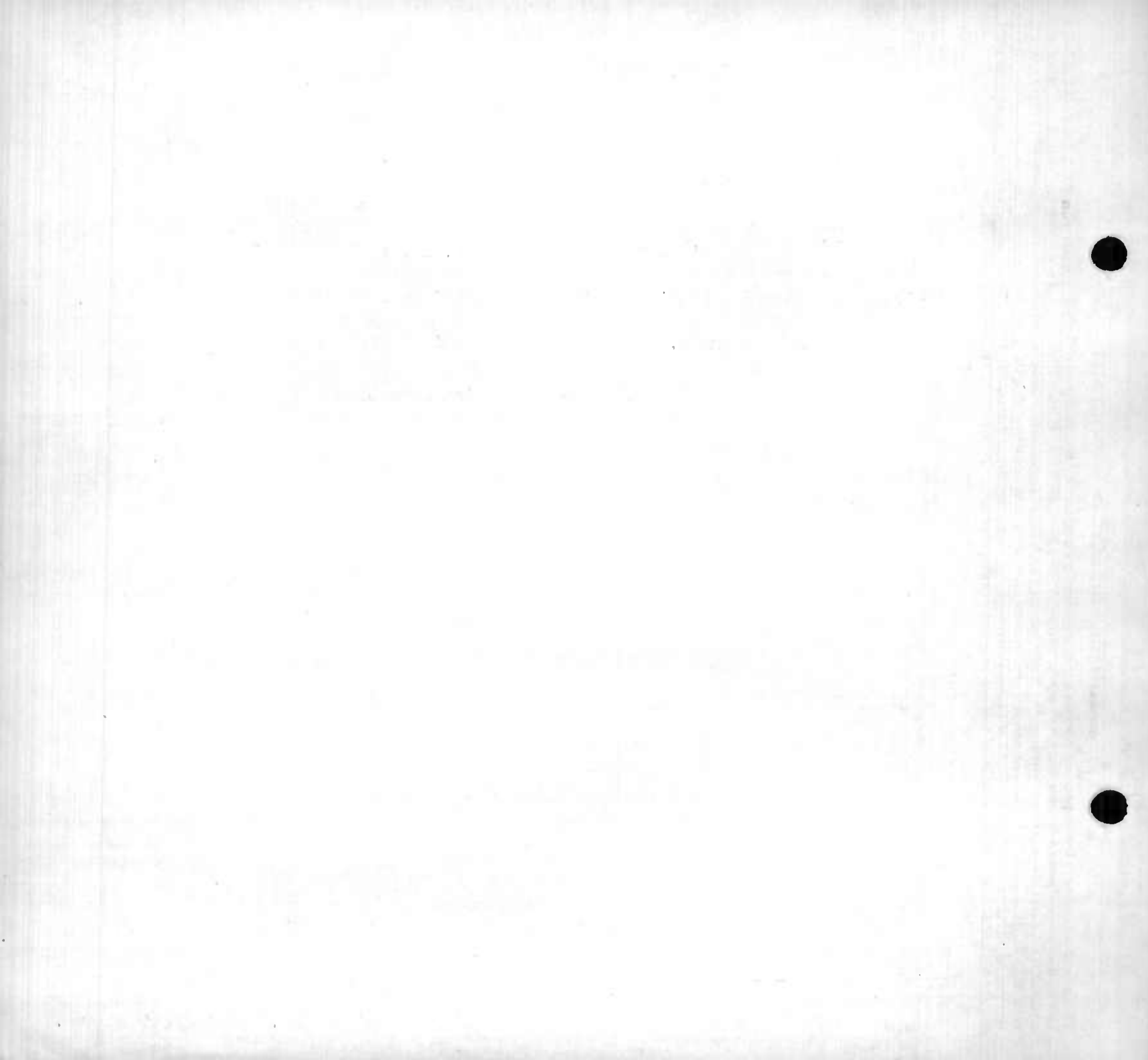
| BIRTH NO. 65 13486 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 13486 | |
|--|-------------------------|--|---|---|----------------------------|---|-----------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Gertrude M. Jones</i> | | | | 2. DATE AND HOUR OF DEATH <i>12/21/65 17:45 A. M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Harford Gardens Convalescent Home</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>7-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>614 N. Potomac Street</i> | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>November 28 1890</i> | 9. AGE (In years last birthday) <i>75</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore County</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Spiegel</i> | | | 14. MOTHER'S MAIDEN NAME <i>Baroline Schaffer</i> | | | 17. INFORMANT ADDRESS <i>Gallut Jones 8048 Philadelphia Road</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no None</i> | | | 16. SOCIAL SECURITY NO. <i>220-30-7170</i> | | | | | | |
| 18. <i>153.8 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Cerebral of color</i> DUE TO (B) DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 19 65</i> to <i>12/21 19 65</i> , that (I) (we) last saw the deceased alive on <i>12/20 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Joseph R. Schubert</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | 23B. DATE SIGNED <i>1/3/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOSEPH R. SCHUBERT</i> M.D. | | | | | | 23D. ADDRESS <i>3508 BAY ST - Baltimore, Maryland</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/3/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Jerusalem Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>4605 Belair Road Baltimore Md</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher</i> | | 25C. FUNERAL DIRECTOR <i>Friedrich W. Miller</i> | | ADDRESS <i>3079 Monument St</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

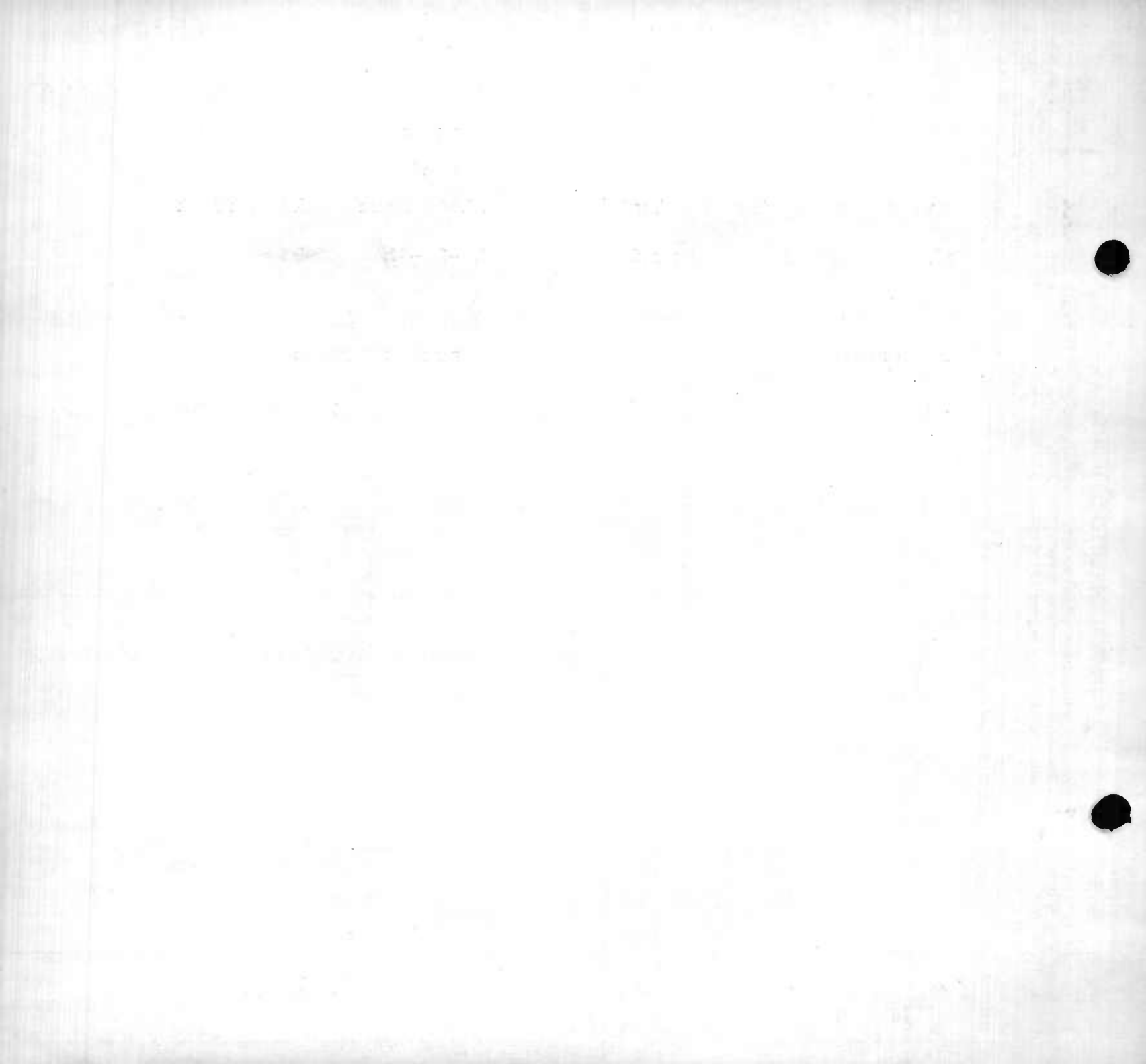
| BIRTH NO. 65 13487 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13487 | |
|--|------------------|--|------------------------------------|---|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) DAVID C. HELM | | | | 2. DATE AND HOUR OF DEATH December 31, 1965 3 15 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2014 Bank Street | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2014 Bank Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH Sept. 29, 1889 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Park Board | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore City | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Helm Sr. | | | | 14. MOTHER'S MAIDEN NAME Annie Howard | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-12-3661 | | 17. INFORMANT ADDRESS Miss Joan Helm 2014 Bank Street | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) EMPHYSEMA DUE TO (B) CARDIOVASCULAR DISEASE DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs 1 yr. + | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from Dec 19 1965 to Dec 31 1965, that (I) (we) last saw the deceased alive on Dec 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE George D. Lippy | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12/31/65 | |
| 23C. PHYSICIAN'S NAME (Type) George D. Lippy | | | | 23D. ADDRESS M.D. 426 S. Patterson PK Ave Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-4-1966 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. | | ADDRESS 1901 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

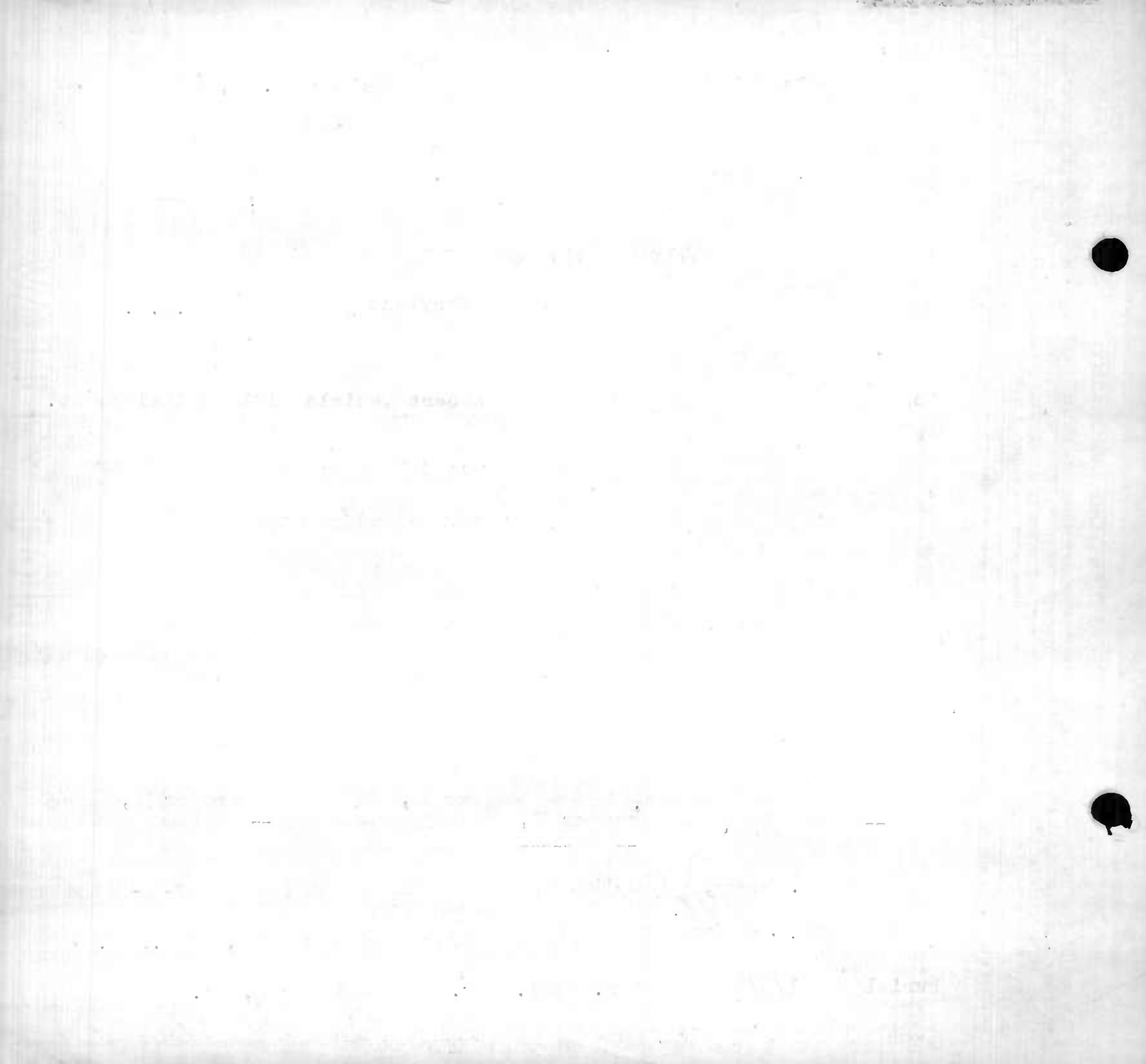
| | | | | | |
|--|-------------------------|--|-------------------------------------|--|--|
| BIRTH NO. 65 13488 | | BALTIMORE CITY HEALTH DEPT. | | Registered No. 65 13488 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mason, Charles ^{OR} Charlie P. | | 2. DATE AND HOUR OF DEATH Dec 29, 1965 7:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-05 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1840 North Wolfe Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10-28-05 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Waste Paper Co. | | 11. BIRTHPLACE (State or foreign country) South Hampton Co., Va. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Tom Mason | | 14. MOTHER'S MAIDEN NAME Harriet Arkert | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-05-7272 | | 17. INFORMANT Mrs. Hettie Mason | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cerebrovascular Accident DUE TO Atherosclerotic Cardiovascular + Cerebrovascular disease (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/15 19 65 to 12/29 19 65 , that (I) (we) last saw the deceased alive on 12/29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. Eugene Page | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) E. Eugene Page | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE H-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) A.A. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley | |
| 25C. FUNERAL DIRECTOR Randolph J. Collick | | ADDRESS 1426 E. Preston St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|-----------------------------|---|--|
| BIRTH NO. 65 13489 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13489 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mildred Carter | | 2. DATE AND HOUR OF DEATH 12-28 AM Dec. 31, 1965 12.28 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 905 NORTH GILMORE STREET | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED Widowed | 8. DATE OF BIRTH 12-8-27 | 9. AGE (In years last b' day) 38 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME ROBERT DANIELS | | 14. MOTHER'S MAIDEN NAME SALLIE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Robert Daniels 1011 Whitelock St. | |
| 18. 754.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Intracranial hemorrhage DUE TO (B) Probable A-V malformation DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 6 hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) No | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from December 30, 1965 to December 31, 1965, that (I) (we) last saw the deceased alive on December 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Jay B. Jensen, M.D. | | 23B. DATE SIGNED 12-31-65 | | 23C. PHYSICIAN'S NAME (Type) Jay B. Jensen, M.D. | |
| 23D. ADDRESS Johns Hopkins Hospital, Balto., Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 1/5/66 | | 24C. NAME OF CEMETERY or CREMATORY Balto. Natl. Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert B. Jensen | | 25C. FUNERAL DIRECTOR ADDRESS Hoyt A. Kohn 1348 N. Calhoun St | |



65 13490

BALTIMORE CITY HEALTH DEPARTMENT

65 13490

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KENNETH C WILSON

2. DATE AND HOUR PRONOUNCED DEAD

December 29, 1965 10:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

722 N. Fremont Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

722 N. Fremont Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

May 17 1905

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kingston Jamaica

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Marie Blackiston 1102 Edmondson Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/30/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-3-66

23C. NAME of CEMETERY or CREMATORY

Arboretum

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 3 1966

Robert E. Farkas

L. H. Nelson 1348 N. Calhoun St

VALLEY HOUSE

65 13491

BALTIMORE CITY HEALTH DEPARTMENT

65 13491

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS GEE (Lewis E.)

2. DATE AND HOUR PRONOUNCED DEAD

December 29, 1965

1:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2321 W. North Ave.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12/8/19

9. AGE (In years
last birthday)

46 XX

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Gee

14. MOTHER'S MAIDEN NAME

Helen Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

John L. Gee 2427 Madison Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of the head

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Corner of North Ave. and Ruxton Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12-28-65 11:50 P.m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Shot in head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/13/65

23C. NAME of CEMETERY or CREMATORY

Carver Mem. Pk.

23D. LOCATION

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

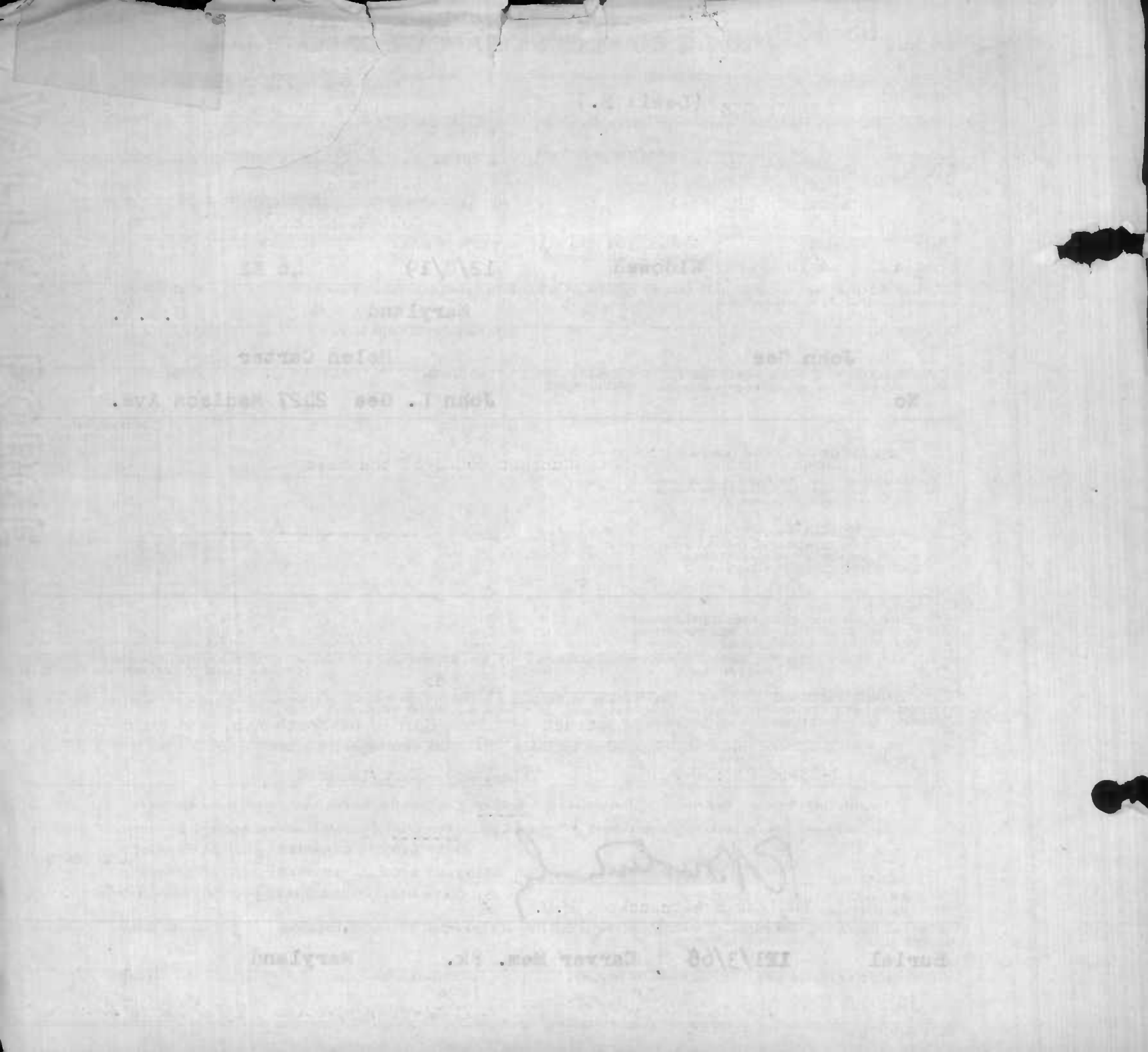
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

George J. Kline 1348 N. Calhoun St.



1
D-120

65 13492

BALTIMORE CITY HEALTH DEPARTMENT

65 13492

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE

DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

December 30, 1965

10:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

513 McMechen Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

513 McMechen Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

NOV-24-1915

9. AGE (in years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retiree

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Clarence Davis

14. MOTHER'S MAIDEN NAME

Marion Costley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

215-07-0715

17. INFORMANT

Raymond Davis 2644 Boone St

ADDRESS

18.

443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
12/30/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-31-65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cem A.A. Co

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Rayner Sanders 217 G. Preston St

ADDRESS

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M 250

65 13493

BALTIMORE CITY HEALTH DEPARTMENT

65 13493

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND J. MCGOWEN

2. DATE AND HOUR PRONOUNCED DEAD

December 21, 1965 9:41 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2915 Ellicott Drive

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Sep

8. DATE OF BIRTH

5-2-1934

9. AGE (In years
last birthday)

31

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during last working life, even if retired)

Teacher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert McGowen

14. MOTHER'S MAIDEN NAME

Beatrice McGowen Blake

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

war II

16. SOCIAL SECURITY NO.

215-30-9152

17. INFORMANT

Beatrice McGowen

ADDRESS

18.

E976X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, lmn, factory, street, office bldg,
etc.)

Parking Lot

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Rear of 221 N. Fremont Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
12 21 '65 P

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
12/22/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Rayner Sanders 2178 Preston St

ADDRESS

WALLLEY & CO

B-000

| BIRTH NO. 65 13494 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 65 13494 | |
|--|---------------|--|--|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) JOSEPH W. BOWIE | | | | 2. DATE AND HOUR PRONOUNCED DEAD December 30, 1965 11:10 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secour Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-03 D. STREET ADDRESS (If rural, give location) 6 S. Payson Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Aug. 9, 1901 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME James A. Bowie | | | 14. MOTHER'S MAIDEN NAME Mary R. Brown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-07-7527 | | 17. INFORMANT Beatrice Bowie Same ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease. DUE TO (A) _____ (B) DUE TO _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. DATE OF OPERATION 0 | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) | | 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner [] CHIEF MEDICAL EXAMINER [] M.D. ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER [] ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D. DATE SIGNED 12/30/65 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 1/3/66 | | 23C. NAME OF CEMETERY or CREMATORY Ashburton Mem. Ch. Baltimore Md. | | 23D. LOCATION (City, town, or county) (State) | |
| 24A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 24B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 24C. FUNERAL DIRECTOR Ashington Phillips 1727 N. Monmouth | | | |

WATLEY FORD

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|---|--|--|
| BIRTH NO. 65 13495 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13495 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Howard Wilson</i> | | | 2. DATE AND HOUR OF DEATH <i>12-31-65 5:25 A.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i> | | | A. STATE <i>MD.</i> B. COUNTY <i>20-02</i> | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 23</i> | | | D. STREET ADDRESS (If rural, give location) <i>3112 Pennrose Ave.</i> | | |
| 5. SEX <i>M</i> | 6. RACE <i>N</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>6-14-30</i> | 9. AGE (In years last birthday) <i>35</i> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Clad L. Clark</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mary Green</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>213-25-3566</i> | | 17. INFORMANT <i>Hospital Chart</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>581.01 Nutritional Anorexia</i> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from <i>12-30-65</i> to <i>12-31-65</i> , that (I) (we) last saw the deceased alive on <i>12-30-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Dr. Lindenstien</i> | | | | 23B. DATE SIGNED <i>12-31-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Dr. Lindenstien</i> | | | | 23D. ADDRESS <i>Maryland General Hospital</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/3/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mount Calvary Co.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR <i>Robert E. Farley</i> | | | |
| 25D. ADDRESS <i>3035 W. North Ave.</i> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

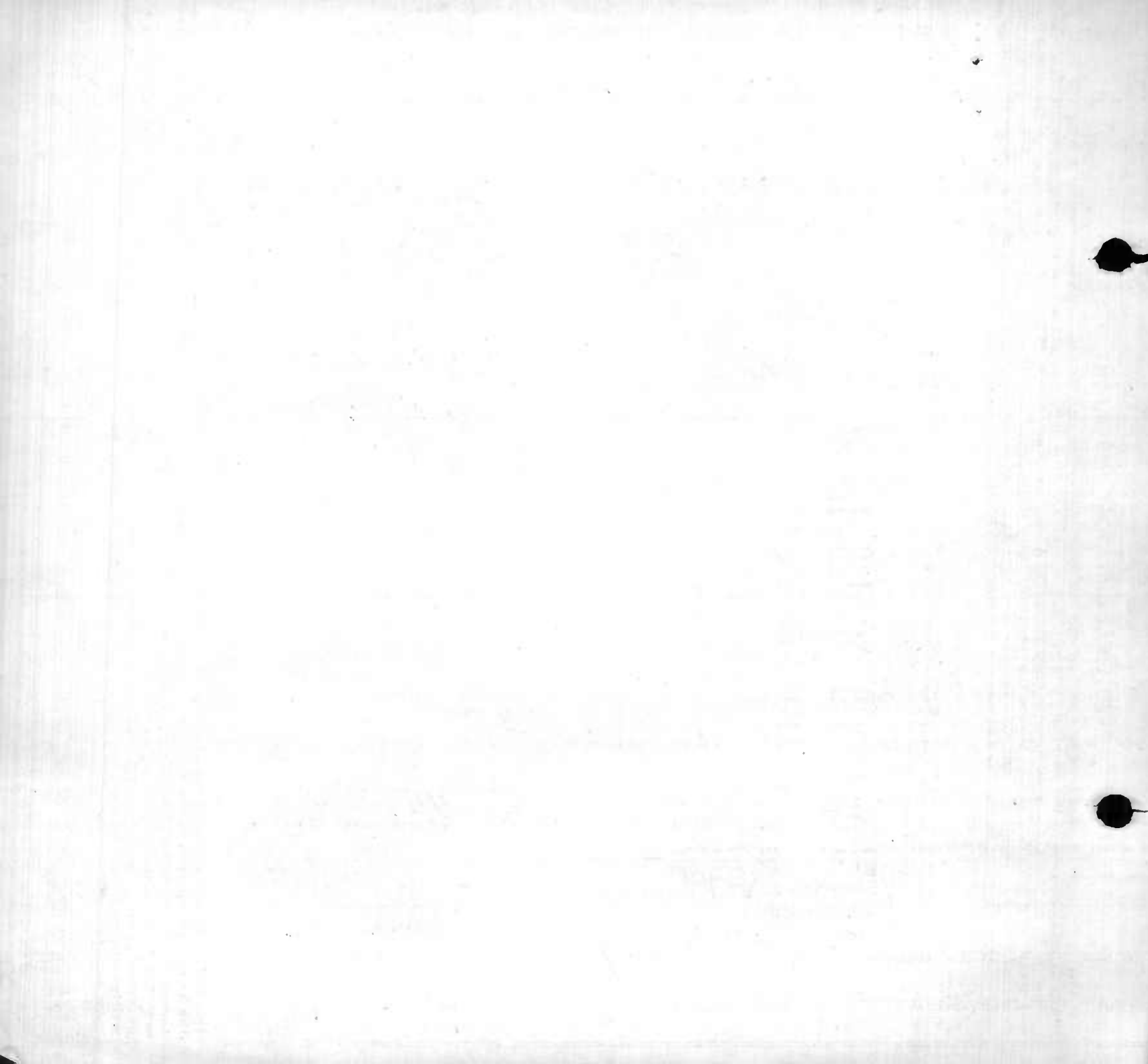
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------------------|---|---|--|---|
| BIRTH NO. 65 13496 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 13496 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Richard Washington Tyler | | | 2. DATE AND HOUR OF DEATH Dec 26, 1965 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1539 Division Street | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8/11/1898 | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Setter | | 10B. KIND OF BUSINESS OR INDUSTRY Southern Glass | 11. BIRTHPLACE (State or foreign country) New Kent Co. Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Thomas Tyler | | | 14. MOTHER'S MAIDEN NAME Elizabeth Hayes | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-07-3722 | 17. INFORMANT ADDRESS James C. Tyler-2112 Dukeland St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Generalized Arteriosclerosis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 hr |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-26-65 to 12-26-65 19 65 , that (I) (we) last saw the deceased alive on 12-26-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Franklin Phillips M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 12/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips | | 23D. ADDRESS M.D. 558 McMillan St Balto. Md. | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/29/65 | 24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | 25B. NAME OF REGISTRAR Robert E. Sutter | | 25C. FUNERAL DIRECTOR ADDRESS Herbert D. Sutter-3035 W. North Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|----------------------|--|--|---|--|---|--|--|--|
| 65 13497 | | | | | 65 13497 | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Theodore Sohl</i> | | | | | 2. DATE AND HOUR OF DEATH <i>12/31/65 12:30 P.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>523 Mt. Holly St.</i> | | | | | A. STATE <i>Md</i> B. COUNTY <i>20-07</i> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Boeto</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>523 Mt. Holly St</i> | | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>W.</i> | 7. MARRIED, NEVER MARRIED <i>Married</i> | | 8. DATE OF BIRTH <i>Sep. 28/88</i> | 9. AGE (In years last birthday) <i>77</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>B.O.R.R.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>Sohl</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mrs. Ruth Sohl</i> | | |
| | | | | | ADDRESS <i>523 Mt. Holly St</i> | | | | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>194X I</i> | | | | | CAUSE OF DEATH (A) <i>THYROID CARCINOMA</i> DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 mos +</i> | |
| II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/1 1965</i> to <i>12/31 1965</i> , that (I) (we) last saw the deceased alive on <i>12/30 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Thomas E. Roach</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>1/1/66</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Thomas E. Roach</i> | | | | | 23D. ADDRESS <i>5535 Baltu Mart Fire Bldg 28 Md</i> | | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE <i>Jan 3/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Lawson</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR <i>Witzke & Co.</i> | | ADDRESS <i>4101 Edmondson Ave</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|----------------------------------|--|--------------------------------|--|
| BIRTH NO. 65 13498 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13498 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Sophia Kirst | | | Dec. 30/65 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 22 S. Athol Ave. | | | A. STATE Ma. B. COUNTY 28-04 | | |
| 5. SEX Female | | | 6. RACE White | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | | 8. DATE OF BIRTH Jan. 24/88 | | |
| 9. AGE (In years last birthday) 77 | | | 10. If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Alfred Kirst | | | 14. MOTHER'S MAIDEN NAME Johanna Heese | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Records, German Home, 22 S. Athol Ave | | | ADDRESS | | |
| 18. 446X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) Uremia DUE TO (B) Arteriosclerotic nephrosclerosis DUE TO (C) Arteriosclerotic Myocardial degeneration. | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1963 to 30 Dec 1965 , that (I) (we) last saw the deceased alive on 30 Dec 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William J Bryson MD | | | 23B. DATE SIGNED 31 Dec 65 | | |
| 23C. PHYSICIAN'S NAME (Type) William J Bryson | | | 23D. ADDRESS 4605 Edmondson Ave Balto 29 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | | 24B. DATE Jan. 3/66 | | |
| 24C. NAME OF CEMETERY or CREMATORY Balto. Cemetery | | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 3 1966 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | |
| 25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave | | | ADDRESS | | |

65-13499

BALTIMORE CITY HEALTH DEPARTMENT

65-13499

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE OWENS

2. DATE AND HOUR PRONOUNCED DEAD

December 31, 1965

4:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Clifton Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
(WIDOWED, DIVORCED (specify))

Married

8. DATE OF BIRTH

April 21, 1900

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Electrician

11. BIRTHPLACE (State or foreign country)

Beaumont

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Wm. G. Owens

14. MOTHER'S MAIDEN NAME

Elizabeth Maisel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Elsie M. Owens

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-31-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan 3/66

23C. NAME OF CEMETERY or CREMATORY

Salem Lutheran

23D. LOCATION

(City, town, or county) (State)

Catonville 28, Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 3 1966

24B. NAME OF REGISTRAR

J. E. G. G.

24C. FUNERAL DIRECTOR

W. H. F. H.

24D. ADDRESS

4101 Edmondson

WALTER FORGE

Walter Forge

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|----------------------|---|-------------------------------------|--|---|
| BIRTH NO. (10) 65 13500 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13500 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Henry H. Schoenfelder | | 2. DATE AND HOUR OF DEATH Dec. 30/65 10:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY GA | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Linthicum Heights | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hosp | | D. STREET ADDRESS (If rural, give location) 105 Hammonds Ferry Rd | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) GA | |
| 5. SEX M | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH May 9/98 | 9. AGE (In years last birthday) 67 | 10. UNDER 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10B. KIND OF BUSINESS OR INDUSTRY O.B. | | 11. BIRTHPLACE (State or foreign country) Balto. Md | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME H. A. Schoenfelder | | 14. MOTHER'S MAIDEN NAME Lena Fischer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-09-7060 | | 17. INFORMANT ADDRESS Mrs. Frances Schoenfelder | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 231X I | | CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage (B) DUE TO Essential Hypertension (238/120) ? years (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from Dec. 29 19 65 to Dec 30 19 65 , that (I) (we) last saw the deceased alive on Dec 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>did not</u> view the body after death. taken to ER. ST AGNES HOSP. | | | |
| 23A. SIGNATURE C. Arthur Rossberg M.D. | | 23B. DATE SIGNED 12/31/65 | | 23C. PHYSICIAN'S NAME (Type) C. ARTHUR ROSSBERG M.D. | |
| 23D. ADDRESS 2436 Washington Blvd Baltimore Md 21230 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/66 | |
| 24C. NAME OF CEMETERY OR CREMATORY Landon A. Balto. Md | | 24D. LOCATION (City, town, or county) (State) Balto. Md | | 25A. DATE REC'D BY HEALTH/DEPT. JAN 3 1966 | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Witt & W. 4101 Edmondson | | 25D. ADDRESS 4101 Edmondson | |

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Handwritten text, possibly a signature or date, located in the lower left quadrant.